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VOLUME I

A Pre-Publication of the Final Report of the Ontario Task Force
on Insurance to the Minister of Financial Institutions
May, 1986





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The Chairman takes full responsibility for the Report and the Recommendations. The Chairman has depended heavily on his advisors and thanks them deeply for their sound counsel. The views expressed in the Report, however, are those of the Chairman and not necessarily those of his advisors.

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EXECUTIVE SUMMARY AND OVERVIEW

Terms of Reference of the Task Force

The Task Force on Insurance was appointed on January 9, 1986, by the Minister of Consumer and Commercial Relations and given a broad mandate to seek out "solutions for cost and capacity problems in the property and casualty insurance industry in Ontario". More specifically, the Task Force was directed to explore "all possible approaches to such solutions which have the result of creating, on a long-term basis, increased market stability, policy holder protection and a climate of economic opportunity for insurance companies in Ontario". These possible approaches include:

- o stricter entry requirements for insurance companies;
- o provisions for ensuring companies have a long-term commitment to the Ontario market;
- o modernization of investment rules for insurance companies;
- o introduction of higher duties and responsibilities for directors and management;
- o rules controlling self-dealing;
- o provisions for greater control over the obtaining of reinsurance;
- o government-run insurance;
- o creation of greater market discipline in the placing and buying of insurance, including greater elements of disclosure;
- o modification of insurance rating practices;
- o rate control of premiums;
- o introduction of prudential rules and regulatory tools to ensure financial soundness of insurance companies;
- o elements of cost control over non-economic loss in liability cases;
- o no-fault insurance;
- o updating rule of corporate governance, with a view to similarity with the Ontario Business Corporations Act, 1982;
- o equal application of rules for the insurance business to all companies operating in Ontario;
- o stronger role for auditors, audit committees and actuaries;
- o promotion of various forms of reciprocal insurance;
- o introduction of rules for prudent underwriting and risk-analysis practices.

The Task Force has interpreted the reference to property and casualty insurance to include the whole field of general insurance with the exclusion of health and accident insurance.

Background

The establishment of the Task Force was prompted by the clear perception on the part of the government that Ontario is experiencing an acute insurance crisis that is having a significant and far-reaching impact on all sectors of the Ontario economy and society. Although most observers agree that the industry is prone to cyclical movements in capacity and prices, it is all too evident that the magnitude and severity of this particular cycle had taken everyone by surprise.

As consumers face huge increases in premiums and in some cases the total withdrawal of capacity, there has been no lack of accusations, counter-accusations, finger-pointing and anecdotal explanations. On the one hand, Ralph Nader and the National Insurance Consumers Organization in the United States, supported by both American and Canadian trial lawyers, argue that the crisis is a scam produced by greedy insurers who are in fact making a great deal of profit in the current market. Others focus on poor management and excessive hysteria within the industry.

For their part, primary insurers blame the crisis on high court awards and so-called "judicial inflation" within the tort liability system. Increased consumer consciousness with respect to insurance claims, together with the withdrawal of reinsurance, are two other related explanations.

Reinsurers likewise blame judicial inflation but also point the finger back at the primary insurers for pursuing the destructive course of cash-flow underwriting during the heady days of high interest rates, and for failing to retain sufficient amounts of risk. According to this argument, the name of the game became the maximization of market share, while letting investment gains offset underwriting losses. Then when interest rates fell precipitously and investment income declined at the same time as claims were rising significantly in terms of both frequency and size, premium income and reserves suddenly

proved woefully inadequate. Reinsurers were called upon to pay the large losses incurred by the smaller insurers in particular, while simultaneously suffering in their international operations from a seemingly relentless series of catastrophes from Bhophal to earthquakes to the Achille Lauro.

Governments and regulators, like the insurance industry, have also received their share of the blame. Everyone has at some stage stressed the failure of public authorities to ensure the solvency and liquidity of insurers (witness the recent insolvencies of five insurance companies), to control rates, and to protect consumers adequately. Remedial suggestions have run the gamut from the creation of a government insurance corporation to minor regulatory tinkering.

Needless to say, the confusion that emerges from the barrage of sometimes conflicting explanations is not easily dispelled, nor are the prescriptions for reform easily identified. Regardless of the precise analysis and conclusions, one conclusion is inevitable: any market that gives rise to the tremendous swings in premium levels and withdrawal in capacity that we have witnessed is simply not operating soundly. Furthermore, although the insurance industry is clearly struggling to respond adequately to the intense internal and external pressures, it does not appear to be able at present to ensure stability in the insurance product.

Task Force Activities

Despite the limitations created by the Task Force's obligation to report in three months, it has sought the views of a wide range of individuals and groups in an attempt to analyze the source of the crisis, and formulate effective recommendations for change. First, a Policy Advisory Group was established that was designed to bring together a variety of persons with expertise in such key areas as insurance, law, accounting, economics and actuarial science. Second, a systematic effort was made to contact certain persons and groups and, more broadly, to solicit the views of any concerned and interested persons on matters relating to the Task Force's mandate. Well over 200 briefs and submissions were received and reviewed by the Task Force, and a substantial number of consultative meetings took place.

This consultation process was extremely useful in identifying the critical problems and possible solutions, and has proved invaluable in formulating the final recommendations of the Report. It should be emphasized that the Task Force has enjoyed the full co-operation of a great number of persons, whether from the insurance industry, the legal profession or insureds themselves. Clearly this greatly facilitated the consultations and permitted the Task Force to proceed expeditiously and constructively at all times.

At the same time, the Task Force was linked to two Inter-Ministerial Advisory Groups established under the Ministry of Consumer and Commercial Relations, as well as the Market Assistance Program and Hot-Line assistance service. As a result, the Task Force was aware of the broad range of concerns confronting the government and the more critical and intractable aspects of the insurance crunch raised by the public.

It was not possible in the short time available to undertake new research. Nevertheless, at an early date, the Task Force commissioned a number of papers and memoranda on various general insurance industry developments and issues. While intended initially as primarily survey and evaluative papers rather than as research papers, many of them bring into focus the accumulated wisdom on key issues and a considered judgment on current and future issues and concerns. Arrangements have been made with the authors for the submission of the work in the public record of the Task Force. These are listed in Appendix 2 of this Report.

In approaching its work, the Task Force has at all times focused on the concerns of the insured consumer and the overriding interest in the availability of adequate and affordable insurance. At the same time, while it has been important to analyze the experiences of other Canadian jurisdictions where the government has directly entered the insurance business, the Task Force has sought solutions within the framework of a private insurance industry that operates effectively, efficiently and fairly from the point of view of the consumer. Finally, the Task Force should emphasize that its investigation of insurance has involved a strong emphasis on the means of enhancing the control of risk and the reduction of losses, as well as simply insuring against risk.

Analyzing the Crisis

The current crisis has highlighted the fact that adequate insurance coverage is essential to the ordinary Canadian, and that the public has a pressing interest in both a stable risk environment and stable insurance product. Insurance permits the individual to cope with future uncertainties by pooling the risk of loss. It permits commercial entities to carry on business in an environment more conducive to economic growth and expansion. The loss of a home or business premise would be a devastating event in the absence of insurance, and major new investments might not be made without the capability of insuring risk. Certainly, a reduction in risk taking would have far-reaching social and economic consequences for our standard of living, as well as significant individual consequences. Yet surprising as it may seem, the general public is only now realizing that the insurance industry is an essential multi-billion-dollar-a-year component of the financial services industry, and of our economic infrastructure, as well as a critical element in our social and economic lives.

The general insurance industry is one in which there has clearly evolved a mix of state/government and market mechanisms, and the need for a government presence in regulating and supervising the provision and availability of the insurance has long been accepted. The basis of this government presence varies and is by no means limited to situations of so-called "market failure" when the private industry is unable to fulfil some essential functions efficiently. Rather the government interest extends to active measures to reduce the probability of loss, to promote the stability of the insurance industry and to facilitate the pooling of risk and uncertainty.

In investigating the causes of the current instability in the insurance market and the extensive cost and capacity problems, the Task Force has been severely hampered by the lack of empirical evidence and data necessary to support or reject a particular theory. Despite some improvements in industry data bases in particular, there is still little meaningful evidence with respect to many critical matters. These include the cost components of bodily injury claims, both automobile and non-automobile, and data on the financial, operational and administrative performance of insurers that would permit a meaningful comparative assessment by the consumer. The Task Force was able

to undertake some limited research into data on court awards and settlements, but emphasizes the need for all concerned to undertake more empirical research and quantitative analysis on a much more systematic basis.

In approaching the analysis of the causes of the crisis, the Task Force began first by focusing on the structure of the industry and the cyclical features of the market. This analysis is set out in Part A. The dominant conclusion that the Task Force has reached is that the crisis does not reflect simply a more severe and unusual cycle of activity which is in the process of being corrected through adjustments in prices and premiums. Rather, the crisis reflects serious socio-legal and economic changes of a structural nature that give rise to such a degree of uncertainty as to permanently alter the risk environment and the insurance market. Thus, certain fundamental reforms to the system are required in order to stabilize the risk environment and ensure the provision of available, affordable and adequate insurance.

More specifically, although as Part A indicates the financial performance of the industry in the aggregate is basically sound, and there is adequate capacity to meet the demand for insurance generally, there are particular areas, notably liability insurance, in which the losses (excess of claims over premiums) have been extreme and the reduction of the capacity is most critical. The climate surrounding such risks has simply become so threatening that insurers refuse to underwrite on the grounds that they are no longer pooling risks but are in effect assuming the risk.

The nature of the structural changes that give rise to such extreme unpredictability and the marked increase in frequency and size of claims are threefold. Firstly, individuals in today's technologically advanced, post-industrial society are being exposed to a growing array of risks and hazards, many of which are highly indeterminate and long range, for example, the as-yet-undetermined effect of environmental pollution or various complex chemical and biological products and processes.

Secondly, concurrent with the proliferation of the risk facing the public and with the widespread availability of general liability insurance, the contemporary insured is far more conscious as a consumer and more inclined to seek compensation for a wide variety of losses.

Thirdly, the pressure to compensate, particularly in the personal injury area, has resulted in a virtual explosion in liability and liability litigation. The law of negligence is being judicially expended and extended to new areas of activity and injury. Courts are certainly at the forefront of these changes, but the driving force behind these changes, and in large part the cause of the "crisis", is the very existence of liability insurance. The phenomenon of modern liability insurance has played a major role in transforming tort and in creating a judicial environment that is becoming increasingly uncertain and unpredictable.

The identification of these structural changes is critical to an evaluation of the assertions that court awards and settlements are escalating out of control and that Ontario is becoming "California North". The Task Force has studied this matter with care, and its analysis is set out in Part B. Much of the current criticism that is being levelled at the court system is rooted in a fundamental misunderstanding of Canadian tort law and how it differs from that of the United States. However, even given these important differences, the Task Force has concluded that the most that can be said is that Ontario is not "California North" -- yet. Notwithstanding the formal differences between the American and Canadian tort systems, the structural similarities are more significant and will ensure continuing uncertainty and unpredictability both in the United States and in Canada.

It is necessary to emphasize that the Task Force is not suggesting the court system or the judges be blamed for the current crisis. Rather it must be recognized that the courts are simply reflecting the deep social, legal and economic changes that have fundamentally altered the risk environment. The courts have responded effectively and with compassion to demands for compensation in the limited situations in which are permitted. The basic problem in the realm of personal injury liability is not any failure of the judiciary to compensate adequately where the law permits compensation. As is explained more fully in Part B, the problem is more systemic: the profound inequity and unpredictability in continuing to use tort as a mechanism for accident compensation.

The Task Force has therefore concluded that, at least in the personal injury area, fundamental reform to the relationship between tort/litigation and the insurance system is required. Accordingly, the Task Force recommends that

steps be taken toward implementing a fundamentally different system of personal injury compensation first, in respect of automobile accidents, but eventually in respect of all accidents. The design of the system will entail the introduction of a system of mandatory first-party insurance coverage set at such levels as to cover the majority of Ontario citizens, together with firm initiatives to enhance the deterrence to hazardous driving such as by means of a bonus-malus penalty rating system. Recommendations for a substantial no-tort system will also be put forward as an alternative.

The Task Force recognizes that many thoughtful proposals have been put forward to reform the tort system in order to enhance its equity and efficiency and assist in improving the effectiveness of the overall insurance system. As set out in Part B, these proposals must be seriously considered and implemented where appropriate. But the Task Force does not believe that these reforms, while valuable in themselves, will address sufficiently the long-term structural changes that are at the root of the extreme uncertainty confronting the insurance industry.

Enhancing the Availability, Affordability and Adequacy of Insurance

In addition to the systemic changes proposed in respect of personal injury compensation, the Task Force has put forward a number of recommendations designed to enhance the availability and affordability of liability insurance. These include proposals in respect of such mechanisms as reciprocal insurance exchanges, self-insurance, insurance pools and the insurance exchange. One important proposal is for an export liability insurance pool to deal with the particularly difficult problems faced by exporters to the United States. All of these proposals require little or no legislative change.

Recommendations are also made in respect of the new claims-made form of insurance policy that has been developed by the insurance industry to help limit long-tail exposures. Given the serious implications of the new form of insurance for potential gaps in and adequacy of coverage, the Task Force believes that the regulators must monitor the situation.

The Task Force has also addressed the need to improve the efficiency of the insurance system and the quality of services provided to the insured. Recommendations to improve the distribution system and reduce the all-too-substantial transactions costs are set out in Part C. These include proposals to improve communications between insureds, brokers and insurers, and to implement changes in the commission rate structure.

Finally, in Part D, the Task Force addresses the need for improved financial regulation and market regulation. Financial regulation refers to the controls placed on the structure of insurers, the financial aspects of their operations and their accountability for such operations. Market regulation refers to the control placed on the relationship between insurers and insureds and their respective rights and obligations, including contracts of insurance, policies, rates, premiums and insurance delivery networks.

The Task Force makes a number of recommendations in Part D with respect to the capital and surplus requirements of insurers and the financial activities of insurers, including investments, reinsurance, reserves, disclosure of information and certain taxation matters. The Task Force views the establishment of a policyholder compensation fund, in which all property and casualty insurers doing business in Ontario would be required to be members as a condition of licencing, as an important government-industry initiative.

The Task Force concludes in Part D that the system of delivering insurance products to the consumer can be improved through specific communication and education mechanisms, particularly with respect to the encouragement of increased risk management. Specific recommendations address the need for agents/brokers to give timely notification to insureds of changes in price, coverage, exclusions and non-renewal.

The Task Force does not recommend the introduction of rate regulation, although it does favour a more systematic framework for the monitoring, surveillance and evaluation of rates. The Task Force also makes suggestions as to how governments may usefully become more involved in property and casualty insurance.

As already noted, the Task Force believes that there is no evidence of any need for the Government of Ontario itself to participate directly in the insurance business. With enhanced regulation to ensure the financial stability of the industry, and an equitable and efficient market for the insurance product, there is every indication that the private insurance industry will be able to provide high-quality and reliable service to the consumer.

In conclusion, the Task Force has put forward a wide range of recommendations designed to address the cost and capacity problems in the insurance market. Since the primary cause of these problems is fundamental socio-legal and economic changes, some of the recommendations involve reform to the very nature of the insurance system itself with respect to personal injury compensation. Other recommendations are directed at changes within the system designed to enhance capacity in the more intractable areas of liability insurance, to improve the efficiency and equity of the system, and to eliminate the high degree of instability in the general insurance market.

P A R T A

THE
INSURANCE
CRISIS:
STRUCTURAL OR CYCLICAL?

PART A

THE INSURANCE CRISIS: STRUCTURAL OR CYCLICAL?

I INTRODUCTION

The current insurance crisis has had a significant and far reaching impact on the Ontario economy and society. In this Part the Task Force examines the sources of this crisis.

Traditional analysis explains the performance of the insurance industry as a cyclical phenomenon, manifested by ebbs and flows in capacity and prices. However, it is now clear that the so-called "Eighth Cycle" cannot be fully explained within the standard framework of analysis that has been applied to previous cycles. The Task Force has therefore concluded that while the cyclical forces inherent in the insurance industry will eventually ameliorate the current situation, simple adjustments to prices and premiums will not completely resolve the problem.

To view the current situation as yet another cycle is inappropriate and would lead to ineffective prescriptions for change. Instead, it must be recognized that the current crisis reflects major technological, social, legal and economic changes that have so fundamentally affected the risk environment and the insurance market that it is no longer possible for the current cost and capacity problems to be overcome within the parameters of the existing system.

In this Part we examine the factors that have so destabilized the current risk environment. This examination is followed by an assessment of the insurance industry's current financial situation and its prospects for the immediate future. The above analyses are intended to identify precisely the characteristics and sources of the current crisis. This, then, will facilitate the more specific analyses and recommendations contained in Parts B, C and D.

II KEY SOCIO-LEGAL CHARACTERISTICS OF THE INSURANCE CRISIS

The Changing Risk Environment

As noted above, it is the opinion of the Task Force that the source of the current insurance crisis is primarily the fundamental changes in the risk environment to which the insurance industry in its current form has failed to respond adequately. These changes are basically threefold:

- (1) the impact of technology;
- (2) concurrent changes in the public attitude and expectations vis a vis risk and compensation; and
- (3) the judicial response to the above two factors.

The Impact of Technology

In today's technologically advanced, post-industrial society, people are being exposed to a growing array of risks and hazards, many of which are highly indeterminate and long range in nature. This development is significant not only because the number of insurable risks is expanding, but also because modern technology has created an environment of uncertainty and unpredictability. For example, the as-yet-undetermined effects of environmental pollution or of various complex chemical and biological products and processes not only demand new insurance products, but also bring into serious question the ability of the industry to even respond to those demands.

Public Attitude and Expectations

Concurrent with the proliferation of the risks facing the public and with the widespread availability of general liability insurance, the contemporary insured is far more "consumer conscious" and more inclined to seek compensation in respect of a wide variety of losses.

This development has underlined the fact that the main function of insurance is to provide compensation. The pressure to compensate has been focussed on the insurance industry, on the government and on the judicial system, and has altered and destabilized the traditional "demand" parameters of the insurance analysis.

The Judicial Response

This pressure to compensate, particularly in the personal injury area, has resulted in a virtual explosion in liability and liability litigation. The situation in Canada has not reached American proportions, largely because of a number of important differences, which are explained more fully in Part B. The differences between the two systems, however, are differences in degree, not differences in kind. The underlying causes of the continuing expansion of liability to new areas of activity and injury are fundamentally similar, and relate in large measure to the role that liability insurance has played in the transformation of the tort system.

This transformation, described in detail in Part B, has placed the courts in a difficult if not impossible position, and has created a judicial environment that is becoming increasingly uncertain and unpredictable.

Conclusion

The current crisis arose because of a conjuncture of the traditional cyclical factors relating to price and capacity, together with the cumulative impact of longer term structural changes arising from an increasing focus on compensation; heightened consumer expectations; greater exposure to risk and hazards; and so forth. Each of these additional factors has the effect of injecting another layer of uncertainty into the risk environment. This uncertainty is exacerbated by the judicial response in the area of personal injury compensation.

Two initial conclusions can be drawn from the above analysis. The first is that in the area of personal injury compensation certain fundamental systemic reforms are advisable. This area is more fully considered in Part B, in which it will be proposed that the government establish a no-tort system of personal injury compensation, first in respect of automobile-related accidents, but eventually in respect of all accidental injuries.

The second conclusion is that it will not be possible to overcome the present crisis with solutions designed only to address its cyclical features. Rather, we must address ourselves directly to the significance of the added element of uncertainty that the above factors have added to the industry.

The Significance of Uncertainty

In a paper prepared for the Task Force, Mathewson and Winter review the main grounds on which property and casualty insurance differ from other market-based goods.¹ They emphasize that the most important difference is the contingent nature of the insurance contract. At the time of the sale of the insurance contract the potential liability assumed by the insurer is in the future and is therefore necessarily indeterminate. The magnitude of the risk assumed by the insurer depends on the degree to which the probability of the occurrence of the potential liability being insured against can be accurately predicted.

- (a) These risks are, of course, exacerbated when insurers cannot forecast the nature of anticipated potential liabilities; these risks are further exacerbated when the actions of those insured can influence the likelihood of states where losses occur (moral hazard), or when insurers have incomplete information on the risks that they insure (adverse selection).

The changes in the risk environment have impacted on the contingency element of the insurance industry in two ways. First, the industry is being forced to meet obligations today that may have had their genesis years ago, in a fledgling technology, unbeknownst to insurer and insured alike (e.g., asbestosis). Second, and more important, the uncertainty that is already inherent in the insurance product has been enhanced in the contemporary environment.

As the Mathewson and Winter paper indicates,² the basic effect of any significant increase in the level of uncertainty in the insurance industry is precisely what is being experienced now: significant increases in the price of insurance together with industry-wide retrenchment in underwriting.

As the economic analysis summarized below indicates, paradoxically the present reaction to the increased uncertainty in the industry will most probably result in some short-term recovery by improving the capital base and by returning the cost-profit ratio of the industry closer to its equilibrium point. However, as the economic analysis also indicates, exclusive reliance on the cyclical improvements in the short-term situation would be unlikely to address the endemic problems that face the industry today.

1 Mathewson and Winter, "The Market for Property and Casualty Insurance in Ontario" (April 13, 1986), pp. 4-5.

2 Mathewson and Winter, Part III (4).

III KEY ECONOMIC AND FINANCIAL CHARACTERISTICS OF THE INSURANCE CRISIS

Macro-Analysis

Supply and Demand

The demand for insurance is relatively inelastic. Insurance requirements pervade modern life. Automobile insurance is now a compulsory, essential adjunct of driving. Governments, banks and many non-financial businesses routinely require transactions to be insured as a pre-condition to the transactions themselves. Property insurance is a pre-condition of obtaining a mortgage on a house. And farm produce cannot be moved from elevator to seaboard unless the carrier has insurance. Indeed, not only is the range of mandatory insurance legislation expanding as set out in Appendix 6, but the demand for new and different forms of insurance by the Canadian consumer continues to expand steadily.

As in most activities, there is no "free lunch" in insurance. As the public demands higher compensation, and as the risks associated with modern life escalate in degree and uncertainty, the insurance industry must respond by charging higher premiums. Of course the pricing of insurance is based on many factors, such as transaction costs, investment income and the capital base. Nonetheless, the fundamental price factor is the relationship between claims paid and premiums received.

The rapidly changing demand factors that have helped precipitate the current crisis have been reviewed above. In reviewing the supply factors, it must be emphasized that some supply characteristics are similar for all market-driven structures, while others depend on whether the structure is highly competitive or has strong elements of monopoly or conspiratorial structures.

In North America the supply of insurance is provided mainly by private-sector bodies, including co-ops, mutuals and joint stock companies. To a considerable extent, the private suppliers have to be able to evaluate the contingencies inherent in the insurance contracts they supply, as well as their cost of operation. They must also, over the long run, earn at least a competitive

rate of return on the capital employed. They must cope for a time with the risks of bankruptcy arising from actual claims exceeding the expected value of claims by a significant margin. They must also be innovative as social and technological conditions change.

The consensus of industrial organization scholars who have examined the structure of the general insurance industry in North America is that the supply side of the market is essentially competitive in nature.¹ Entry and exit are easy, both for domestically chartered and foreign chartered insurance firms. Economies of scale and scope are not significant. As a result, the insurance market should be efficient and responsive. As a long-run equilibrium matter, such a market structure is expected, subject to some qualifications with respect to information, moral hazard and adverse risk selection, to yield approximately efficient results in the sense that costs should be minimized and the price of the service should equal the costs -- including opportunity costs -- of capital employed. If more expensive services are demanded, premiums should increase in the long run in line with the increased actuarial value of the benefits together with any increases in transaction costs.

The current pricing experience, especially in the realm of personal liability insurance, has necessitated a re-evaluation of the above basic traditional assumptions.

In their paper, Mathewson and Winter address the issue of whether the competitive model is still viable in light of the observation that recent increases in premiums and reductions of coverage do not reflect the historical record of costs. They argue that increases in the average level of awards and settlements, together with the sort of increased socio-legal uncertainty in the risk environment described by Professor Trebilcock² will typically lead to short-run increases in prices of insurance services that are larger than the increases in coverage costs incurred by the industry. They argue that as uncertainty is replaced by greater certainty over time, the long-run competitive market efficiencies should re-emerge. Thus, premiums will ultimately again be determined mainly by claims and transaction costs.

1 Mathewson and Winter, p. 10.

2 Trebilcock, "The Insurance-Deterrence Dilemma of Modern Tort Law: Trends in North American Tort Law and their Implications for the Current Liability Crisis" (April 21, 1986).

The papers prepared by Mathewson and Winter and by Trebilcock both reaffirm the conclusion that the insurance industry is essentially competitive. However, both papers emphasize that the unusual nature of the insurance product, together with the growing uncertainty associated with the modern risk environment, necessitate an unusual adjustment process for a competitive industry. To understand the nature of this adjustment process it is first important to understand the cyclical nature of the insurance industry.

The Insurance Cycle

While the Task Force has concluded that the current crisis is structurally different from previous cycles, the cycle analysis does provide a perspective from which the true gravity of the current situation can be appreciated. In addition, an understanding of the cycle analysis enables one to recognize the basic distinctions between the current situation and the past.

The cyclical experience is set out in a survey paper prepared for the Task Force, included in this report as Appendix 7. That paper is based on more detailed papers listed in the Appendices, and on the many submissions to the Task Force. Only the main arguments and conclusions will be presented here.

The typical features of the insurance cycle can be summarized as follows:

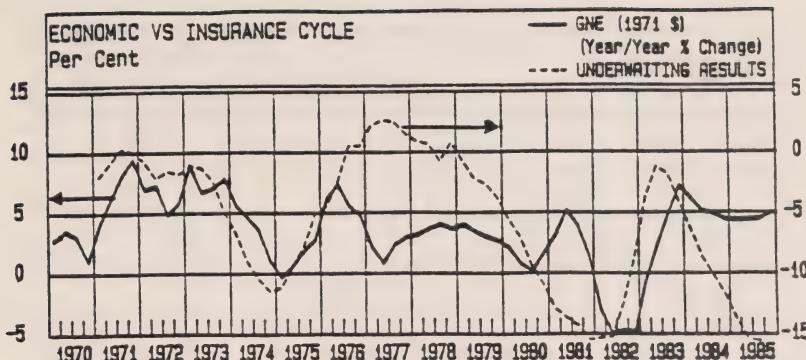
If one starts from a situation of overcapacity in which there is surplus capital against which to write insurance, availability will be high and extended coverages will be offered at lower prices. Self-insurance will shrink as insureds take advantage of the situation to reduce their deductibles. Similarly the incentive to promote risk limitation will be reduced. Generally, this cycle will coincide with a strong economy. Each firm will thus attempt to maximize its market share by underwriting its cash flow. Eventually, the equilibrium price-cost relationship for the industry will be undershot as potential loss and expense levels overtake premium and investment incomes. Capital and surplus will then deteriorate; firms will withdraw or fail; and retrenchment will start to take place, manifested by higher prices, reduced availability, more selective risk-insuring, and reduced adequacy of coverage. This will lead to cancellation and non-renewal of contracts.

Ultimately, higher prices and lower expenses will create better loss ratios and a reduction in reserve requirements, thereby increasing industry profitability. The new entrants attracted to the market together with the increased surplus capital will generate lower prices and increased availability. The equilibrium price-cost position on the high price side will then typically be overshot, and overcapacity will develop. The cycle is then complete.

Reinsurance will usually be dragged along by the cycles in first-line insurance. However, independent factors in the availability of capital, profit evaluation or costs of reinsurance can exercise their own distinctive influences on the overall cycle.

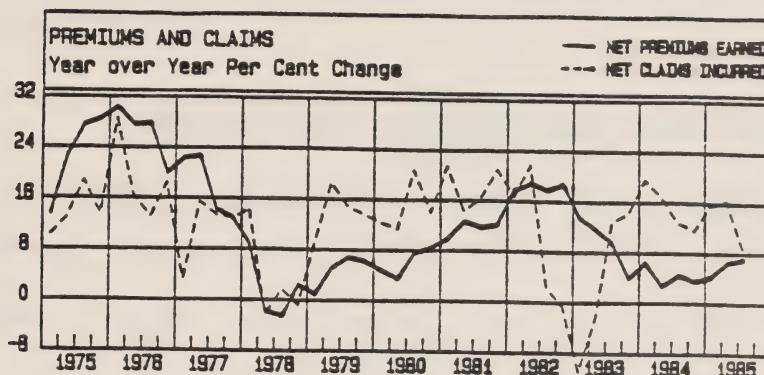
A summary view of the current and some recent cycles in the property-casualty insurance industry is presented in Charts 1 and 2. The insurance cycle is effectively indicated by developments in the underwriting results (defined as net premium income less the sum of net claims incurred and expenses and dividends as a per cent of net premium income). If this ratio is -10% for example, an underwriting loss equal to 10% of the premium income has occurred, (i.e., net claims incurred and expenses and dividends have exceeded premium income by 10%). The profitability of the industry may still be positive because investment income might be equal to 15% of premium income.

Chart 1 shows a trough of underwriting loss in 1974-1975, followed by a peak of underwriting profit in 1977. This was followed by a trough in 1981-1982; an unusually short cycle peak in 1983; and a trough of severe losses in 1985. Except for the unusually favourable underwriting profit of 1983, the last five years are an exceptionally long and severe period of underwriting losses. The insurance cycle is quite distinct from the economic cycle, although for obvious reasons economic cycles do have some influence on the specific shape of insurance cycles.

CHART 1

Source: Statistics Canada, Financial Institutions, Cat. No. 61-006 and National Income and Expenditure Accounts, Cat. No. 13.001.

Chart 2 shows that the insurance cycle is mainly due to variations in the rate of growth over time in net premiums earned, rather than cycles in the net claims incurred. Year-to-year changes do take place in net claims incurred but these are, broadly speaking, random rather than cyclical. Chart 2 also shows that, except for the anomaly centring on early 1983, the annual growth rate in net claims incurred has been greater than the average growth rate in net premiums earned. It should also be noted that there has been no trend of acceleration or deceleration (i.e., increase or decrease in the rate of increase) in the total dollar amounts for net claims incurred over the recent past.

CHART 2

Source: Statistics Canada, Financial Institutions, Cat. No. 61-006.

Table 1 presents property-casualty results for eight years ending in 1985. In interpreting these results, two caveats are important. First, the results of government insurance corporations are not included; their operations would account for more than \$2 billion of net premiums earned in 1985. Second, net claims incurred includes additions to claims in reserve made during a given year in anticipation of expected future claims payments.

The table shows several important features of the current insurance cycle. First, 1985 was the worst year of the last eight in underwriting loss, at \$1,260 million. However, it was also the best year ever in investment income, at \$1,350 million, not including extraordinary transactions. Extraordinary transactions -- mainly realized capital gains on the sales of securities -- yielded another \$279 million, and contributed to an overall profit of \$386 million for the industry. The bull market in stocks and the increased prices of outstanding bonds due to the fall of interest rates during 1985 created unusual capital gains, some of which were realized by the industry and would be included in the extraordinary transactions.

Second, during the last five years the compound annual growth rate in net claims incurred has been near 12% per year, compared with a comparable growth rate of premiums earned at about 10% a year. Between 1984 and 1985, however, net claims incurred increased by 13.8%, while net premiums earned increased by only 7.7%.

TABLE I
PROPERTY/CASUALTY INSURANCE INDUSTRY RESULTS
(\$ MILLIONS)

	1978	1979	1980	1981	1982	1983	1984
Net Premiums Written	4,643	4,970	5,328	6,028	7,056	7,456	7,724
Net Premiums Earned	4,560	4,813	5,102	5,690	6,723	7,341	7,639
Net Claims Incurred	2,977	3,390	3,887	4,607	5,019	5,198	5,966
Loss Ratio	64.7	70.4	76.2	81.0	74.7	70.8	78.1
Expenses & Dividends	1,594	1,616	1,788	1,973	2,266	2,471	2,590
Expense Ratio	34.7	33.6	35.0	34.7	33.7	33.7	33.9
Underwriting Profit/Loss	28	(192)	(572)	(889)	(562)	(328)	(917)
Combined Ratio	99.4	104.0	111.2	115.6	108.4	104.5	112.0
Insurance Operations Investment Income	339	408	455	545	602	655	734
Insurance Operations Profit/Loss	367	216	(116)	(344)	40	327	(182)
Other Investment Income (Equity)	243	293	327	391	452	464	521
Income Taxes & Extraordinary Transactions	(168)	(109)	1	113	(37)	(51)	23
TOTAL NET INCOME	442	400	212	160	455	740	362
Income Ratio	9.7	8.3	4.1	2.8	6.8	10.1	4.7

Note: All ratios shown are a percentage to net premiums earned
Source: Statistics Canada, Financial Institutions

Third, a broad judgment can be made about the affordability of property-casualty insurance in the aggregate on the basis of premiums as a percentage of nominal Gross National Expenditure (GNE). Between 1980 and 1985, the burden of insurance costs increased slightly for the Canadian people, from 1.71% to 1.81%.

It has to be conceded that every insurance cycle has its own distinctive features. Also, while the insurance cycle is distinct from general economic cycles, there are interactions between the general economic cycles and the insurance cycles. Nevertheless, the model insurance cycle summarized above appears to be a major cause of the current instability in general insurance.

The fundamental question that derives from the recognition of the cyclical nature of the insurance industry is why does each cycle appear to be characterized by a "recognition lag"? Why is the industry slow to perceive changes in price-cost-loss, in profit cycles and in prospects?

This analysis then generates an additional set of questions. For example, it may be that there is no critical lag at the industry level, but that for some reason individual firms perceive their position and prospects differently from the industry position and therefore lag behind the industry recognition of the problem. If this is so, is it because of diversity within the industry or because of some more fundamental characteristic of the insurance product? In addition, why are actions so discrete and occasional, compared with the continual and incremental changes that characterize most other financial services? What are the patterns of diversity among firms that appear in the process of overall industry adjustment? Do these influence the shape and efficiency of the process?

The Task Force has also considered the additional delay that occurs after action is taken to change the price and availability of insurance services, but before the financial position of the industry reflects those actions.

Finally, the Task Force has considered the current and potential role of rating bureaus, industry associations, financial market analysts, and regulators in influencing these adjustment processes. Would the process and results be quite different if the structure was substantially monopolized or cartelized rather than competitive? Price-regulated, though competitive?

Analysis done for the Task Force indicates that the combination of the competitive structure of the property and casualty insurance industry, together with the extended time-horizons of the contingent contracts that are the heart of the insurance service, and the inevitability that the actual experience for firms from time to time will diverge significantly from expectation, implies that a measure of market instability is an inevitable and continuous feature of the business. But the analysis also suggests that the current instability is excessive, and could be reduced within the framework of a competitive market structure.

The recognition lag is due in part to the gaps and untimeliness in the availability of relevant data, particularly on court awards and settlements, on claims development, on various elements of costs, and for various kinds of insurance lines on both an aggregated and disaggregated basis. As well, there are notorious gaps in the information available about the underlying elements of processes that determine the size and nature of claims paid. Because there are so few listed stocks of property and casualty insurers in Canada and so thin a market in these equities, the investment community does little research and evaluation on general insurance companies. Canada is much worse off than the United States in this respect. In addition, little scholarly research is done in Canada on insurance subjects. Similarly, few economic and financial journalists have shown interest in the subject.

The Task Force has also concluded that there is a distinct lag in action behind recognition. Even after a number of observers pointed in late 1984 and early 1985 to incipient hard market conditions, little action was taken by insurers, insureds and brokers and agents until late 1985 and early 1986. A primary explanation for this lag is the diversity of positions of individual firms within the industry, together with a worry about the serious consequences of being the first firm to raise prices or retrench. Losing market share and incurring the costs of rebuilding market share later are widespread deterrents to an individual firm considering increasing prices and reducing availability of general insurance early in a cycle. Decision-makers in the insurance industry are more often optimistic than pessimistic. When this optimism is combined with the time-horizons of the contingent contracts, putting off to tomorrow the unwelcome decision to increase price is a seductive alternative.

Finally, a third time lag draws out the cycle. A significant delay is generally experienced between implementation and the decision to change the

price and availability of insurance. This delay is explained by the heavy dependence on brokers and agents, and by the use of rate manuals as the vehicles for pricing contracts. It inevitably takes time for the translation of decisions into new pricing and availability guides, and then again for the brokers and agents to put those into use. A bank can change its interest rate daily if it wishes, but property and casualty insurance companies in Canada work with systems that entrench a good deal of inertia. The new rates become effective only on renewals and when new business is written. Renewals are scheduled throughout any given year. In addition, remittances from brokers and agents to insurers are subject to a lag.

The threefold time lag in responding to the demands of the insurance cycle explains in part why the effect of the down-cycle is felt so hard. The delay in response manifests itself in a number of ways. First, the recognition delay means that the industry does not respond until the situation is poor. When sufficient companies have crossed the threshold of prospective -- or actual -- serious difficulty the price increases that result are often abrupt and disproportionate to the actual situation.

In addition, reaction to a down-cycle can be exacerbated by the large shifts of mood that can accompany any major industry change. The potentially disruptive effect of distorted perception from within the industry is heightened in insurance because of the much greater role of uncertainty in the business.

Similarly, because the insurance industry is unable to effectively respond internally to down-cycles, it is also unable to control or influence public perception -- which, in turn, may exacerbate the problem. For example, when the American public became aware of the massive increases in potential liabilities associated with asbestos, the claims made by businesses on their insurers escalated by an order of magnitude that was, at the time, unable to be accurately specified. Once people became alarmed over these developments, the uncertainty that then attached to other related product liabilities and to medical malpractice costs was huge and became increasingly difficult to transform into insurable risks, because little hard data existed on which to confidently base premium rates. Canada has experienced the same sort of concern over escalating awards and settlements for liability. And similarly, it has proved almost impossible to allay these concerns and expectations because so little hard evidence has been gathered and analyzed.

The above conclusions are bolstered by comparisons across lines of insurance. Where there are large bodies of quantitative experience, long histories of good quality industry analysis, clear indications of both micro-level and macro-level experience, good records of use of reinsurance, and no massive shifts in uncertainty, few surprises are found. Adjustments for the personal lines of automobile and property insurance show these characteristics. These lines are not completely free of problems, nor from instability -- the open-endedness in compensation for bodily injury has inevitably influenced them -- but comparatively speaking, the degree of instability is not large. However, when one turns to insurance lines characterized by high uncertainty, such as product liability, medical malpractice, and environmental and pollution damage, the shifts in uncertainty and the paucity of hard evidence have given rise to massive instabilities in premiums, availability, adequacy and affordability.

Proposals for the Amelioration of the Effects of the Insurance Cycle

The above analysis indicates that the most important factor required to improve the efficiency of adjustment within the insurance industry is the improvement of the supply and analysis of information about the industry itself.

Industry data-gathering, information, analysis, research, rating and risk management organizations have existed in the fields of property and casualty insurance services for a long time. However, they are somewhat inhibited in their activities lest they be treated as acting to restrain competition, which is illegal under the Combines Investigation Act. The industry associations have provided hard evidence and good analysis for a long time on many subjects. However, there are gaps that, if filled, would significantly reduce the current instability, and would improve the industry ability to respond to ongoing structural demands.

Members of the industry associations have been proprietary regarding some crucial elements of information, including awards and settlements, claims development, claims reserves and the details of the underpinning to these elements. Proprietary restraints have also affected the availability of critical industry information on risk retention and reinsurance activities. In neither of these broad areas is information on individual companies required; industry data with some sub-classifications would suffice. To some extent the paucity of information reflects a judgment that the data would not be worth the cost of

collection and analysis. In the light of recent experience this appears to be a short-sighted view.

Improved information about awards and settlements, the frequency of claims, and the social patterns and costs of the adjudication process are required to improve industry management. Improved information would also assist market development; the reinsurance process; law making and regulation; and would enable us to demonstrate that Ontario is not "California of the North", and thereby placate the mounting public concerns about a legal and compensation system grown out of control.

In addition, more systematic and timely analytical research on the performance of the property and casualty insurance sectors is needed. If such research is not generated by the investment community, scholars, public affairs analysts and empirically minded legal scholars, then more reliance will have to be placed on industry associations. Inevitably, however, such research will always be tainted as somewhat self-serving. Some independent analysis is therefore required. The concerns of the governments responsible for insurance matters should extend to include more research. In the opinion of the Task Force, an analytical review of the insurance industry by Parliamentary and Legislative committees should be at least an annual affair.

One of the central issues arising out of the stability analysis is whether public authorities should have some regulatory power to promote more efficient and timely adjustments by the industry of the price and availability of insurance services. Presumably, such activity could be carried on by a branch of a financial services ministry or agency that is separate from the solvency control branch. However, even if a government agency had the information and analytical capability to attempt to steer markets to faster and more appropriate adjustment, one must first determine whether it should be permitted to do so. Who will be responsible if governments push price increases earlier and in larger degree than the competitive market is capable of handling? What will be the liability of the government if a number of firms get into trouble by following government advice or direction? These issues are considered in detail in Part D of the Report.

Affordability

An analysis of average family expenditures in Canada indicates that personal insurance costs are minor budgetary items (see Table 2). During 1982, personal insurance payments made to the property-casualty industry (tenants' insurance premiums, homeowners' insurance premiums, and vehicle insurance premiums) accounted for only 2.0% of the family expenditure budget. Other insurance-related expenditures include: health insurance premiums (private and public), 0.7%; life insurance premiums (including group insurance premiums), 0.8%; unemployment insurance, 0.9%; and retirement income maintenance, 2.5%.

Although a relatively minor budgetary expenditure, sharp increases in personal insurance premiums have stretched those on tight budgets and created uncertainties in the budgeting process. A similar conclusion can be drawn for municipalities and hospitals faced with large premium increases. The exception in these situations is the unavailability of coverage in certain cases and the consequent resorting to reciprocal insurance arrangements.

TABLE 2
Average Expenditure in Canada, 1978 and 1982
All Families and Unattached Individuals

	Dollars		Per Cent of Total Expenditure	
	1978	1982	1978	1982
Food	3,188.5	4,131.1	16.8	15.3
Shelter	3,060.7	4,742.0	16.1	17.5
Tenants' insurance premiums	3.0	22.0	0.0	0.1
Premiums for insurance on home	65.4	146.2	0.3	0.5
Household Operation	782.0	1,177.1	4.1	4.3
Household Furnishings and Equipment	868.4	972.0	4.6	3.6
Clothing	1,298.7	1,650.6	6.8	6.1
Personal Care	312.6	490.8	1.6	1.8
Medical and Health Care	368.1	522.2	1.9	1.9
Health insurance premiums	142.4	190.0	0.7	0.7
Tobacco and Alcoholic Beverages	613.6	892.2	3.2	3.3
Transportation	2,425.6	3,270.6	12.7	12.1
Vehicle insurance premiums	241.8	382.3	1.3	1.4
Recreation	947.7	1,261.4	5.0	4.7
Reading	108.1	157.9	0.6	0.6
Education	121.3	188.3	0.6	0.7
Miscellaneous	461.9	796.5	2.4	2.9
Total Current Consumption	14,557.2	20,252.8	76.5	74.8
Personal Taxes, Security and Gifts	4,476.6	6,809.4	23.5	25.2
Life insurance premiums including group	175.5	220.0	0.9	0.8
Annuity contracts	27.5	38.1	0.1	0.1
Unemployment insurance payments	163.8	254.0	0.9	0.9
Retirement and Pension Fund payments	425.4	649.7	2.2	2.4
TOTAL EXPENDITURE	19,033.7	27,062.3	100.0	100.0

Note: Details may not add due to rounding.

Source: Statistics Canada, Family Expenditure in Canada, Cat. No. 62-551 and 62-555, Occasional Percentage Calculations by the Economics Practice, Coopers & Lybrand.

Macro-Analysis: Conclusion

Although the overall profitability of the property-casualty insurers is more unstable from year to year than that of other financial services, partly as a consequence of the insurance cycle, the overall financial record is fairly strong. The average rate of return on equity during the period 1979-1984 for the industry as a whole is 9.3%. The property-casualty industry in Canada is one of the best capitalized industries in the economy. Over the past 15 years, equity held in the industry has grown at an annual compound rate of 11.2%, from \$958 million in 1970 to \$5.7 billion during the third quarter of 1985. (See Appendix 7.) An examination of the composition of the equity reveals that retained earnings and head office accounts (a measure of the initial seed capital and retained earnings attributable to Canadian branches of foreign companies) are the major items.

In view of the instability of profits, one might have expected that the average rate of return on equity in the property casualty insurance industry would have to be slightly higher than the Canadian average, to compensate for the risk and variability. However, the average appears to be slightly below some obvious alternatives such as banks and trust and loan companies. The high retention rate of profit in the industry and the strong growth in equity point to the underlying strength of the industry. There are no signs of major capital withdrawals, so that can be ruled out as an element in the insurance crisis. Indeed, from an overall point of view, the capacity of the industry to supply insurance is far from being strained. Why then are insurance services sometimes unavailable or prohibitively expensive?

The macro-analysis highlights two contributory reasons. The first being the long-term instability created by the over-reliance on investment income. The second is the problem of slow industry response to the ongoing cyclical and external changes that impact on the industry. A more complete answer, however, is provided from a micro-analysis perspective.

Insurance Cycles: Micro-View

The nature of the current problems begin to emerge when a more micro approach is taken, wherein the trends and cycles for particular lines of insurance are examined along with the problems of particular groups of insurers facing particular kinds of risks.

General liability insurance accounts for about 5% of the premiums of the property and casualty insurance industry, but for about "half" the problems. It is the locus of the worst deterioration of loss ratios. Liability lines are where the sharpest increases in claims reserves have occurred in recent years.

In general liability insurance whole classes of insureds have faced premium increases of 50%, 100% and occasionally 500% along with coincident reductions of coverage. However, for automobile insurance, which accounts for more than 45% of the total premium dollars, and for property insurance, which makes up about 40%, no massive general problems have arisen in the cycle.

Table 3 has been supplied by the Insurance Bureau of Canada. For property insurance, loss ratios in 1985 have increased a little from the 1983 and 1984 levels, but they are not above the average for the last six years. The loss ratios for automobiles have deteriorated somewhat more lately and are slightly above the six-year average. The losses are not acceptable from a long-term point of view, but massive increases in premium rates are not required to bring about an acceptable balance. Thus, for at least 85% of insurance services to the public, no major price or availability problem arises. The level of and deterioration in loss ratios in liability insurance are startling by comparison.

These views of the issues are sharpened by Charts 3 and 4. Chart 3 shows the recent trends in insurance experience for private passenger third-party liability. This is the coverage by which a person's insurer pays for bodily injury and property damage to other people arising from automobile accidents. Average premiums for third-party liability have lagged increases in the Consumer Price Index (CPI), the Insurance Advisory Organization (IAO) recommended rate, and claims losses. The IAO data also shows that after adjustment for inflation, the average premium for third-party liability experienced a cumulative decline of 11.2% over the six years.

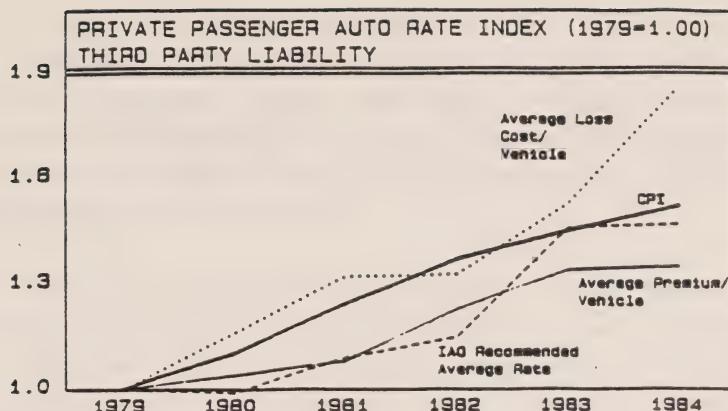
In the paper prepared by Coopers & Lybrand, a general liability rate index has been set out. That experience suggests that earned premiums are significantly inadequate to cover losses and have lagged increases in the CPI by a substantial margin. After adjustment for inflation, earned premiums have experienced a cumulative decline by 1984 of 28.9% over the six-year period, reflecting competitive pricing practices.

TABLE 3

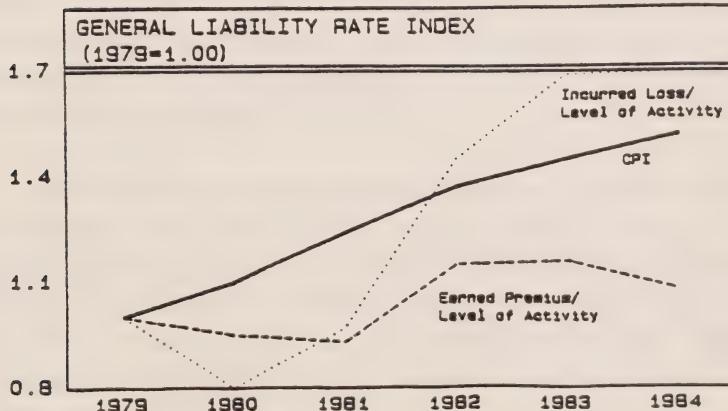
Earned Premium, Incurred Losses^a and Loss Ratio by Major Class

PROPERTY										AUTOMOBILE										LIABILITY									
	Earned Premium	Incurred Losses	Loss Ratio	Year To-Date	Earned Premium	Incurred Losses	Loss Ratio	Year To-Date	Earned Premium	Incurred Losses	Loss Ratio	Year To-Date	Earned Premium	Incurred Losses	Loss Ratio	Year To-Date	Earned Premium	Incurred Losses	Loss Ratio	Year To-Date									
1960	1 436,286	320,160	71.7	73.7	567,824	469,940	82.6	82.6	75,251	45,247	60.6	60.6	456,410	329,218	71.6	61.6	436,410	329,218	71.6	61.6									
	2 451,219	329,412	73.0	73.5	581,677	400,559	69.9	75.0	69,891	42,631	52.7	52.7	376,941	303,327	81.0	63.9	376,941	303,327	81.0	63.9									
	3 473,269	330,672	69.9	72.1	620,161	510,269	82.1	76.0	76,061	51,442	67.4	67.4	382,363	347,730	81.4	67.4	382,363	347,730	81.4	67.4									
	4 572,461	415,594	76.1	73.1	632,363	594,244	94.1	82.3	81,931	44,185	52.6	52.6	472,363	362,339	98.7	52.6	472,363	362,339	98.7	52.6									
1961	1 483,422	386,200	80.0	80.0	621,176	583,748	93.6	91.6	82,675	59,490	59.9	59.9	484,422	322,104	64.0	64.0	484,422	322,104	64.0	64.0									
	2 505,441	314,397	64.2	72.9	657,622	503,558	76.6	84.9	86,881	52,444	62.2	62.2	505,441	49,764	20.2	20.2	505,441	49,764	20.2	20.2									
	3 541,046	403,235	74.5	73.1	697,594	597,215	85.4	85.1	85,444	52,768	62.4	62.4	526,594	162,768	101.7	101.7	526,594	162,768	101.7	101.7									
	4 605,221	476,848	78.8	75.0	726,649	697,119	95.9	84.0	86,753	52,768	62.4	62.4	526,649	162,768	101.7	101.7	526,649	162,768	101.7	101.7									
1962	1 561,503	445,521	82.9	82.9	749,301	663,469	88.1	88.5	94,491	63,794	72.8	72.8	561,503	50,431	60.2	60.2	561,503	50,431	60.2	60.2									
	2 591,584	397,750	64.8	74.6	792,076	541,280	66.4	78.3	102,513	50,431	60.2	60.2	591,584	50,431	60.2	60.2	591,584	50,431	60.2	60.2									
	3 617,812	381,218	61.7	70.1	837,958	585,939	69.8	75.3	106,219	54,693	60.5	60.5	617,812	79,921	101.0	101.0	617,812	79,921	101.0	101.0									
	4 654,778	402,346	61.1	67.7	895,821	649,727	77.8	75.8	117,659	119,821	101.0	101.0	654,778	101.0	101.0	101.0	654,778	101.0	101.0	101.0									
1963	1 621,687	381,229	61.3	61.3	860,396	572,892	64.6	64.6	110,920	50,191	61.1	61.1	621,687	116,114	52.6	52.6	621,687	116,114	52.6	52.6									
	2 671,370	375,811	55.8	58.5	876,240	626,666	65.8	65.8	119,365	102,120	67.2	67.2	671,370	102,120	67.2	67.2	671,370	102,120	67.2	67.2									
	3 682,974	425,044	62.2	59.8	902,544	647,878	71.8	67.8	116,661	102,051	67.3	67.3	682,974	117,191	101.0	101.0	682,974	117,191	101.0	101.0									
	4 722,123	460,611	59.6	59.7	940,145	844,494	90.0	73.8	113,611	109,650	100.4	100.4	722,123	109,650	100.4	100.4	722,123	109,650	100.4	100.4									
1964	1 684,646	424,989	62.1	62.1	901,099	711,290	76.0	76.9	116,288	115,287	99.1	99.1	684,646	115,287	99.1	99.1	684,646	115,287	99.1	99.1									
	2 687,288	431,509	62.9	62.9	915,580	666,530	71.8	76.8	112,932	115,319	96.0	96.0	687,288	115,319	96.0	96.0	687,288	115,319	96.0	96.0									
	3 704,726	446,316	63.3	62.7	931,637	760,537	81.8	77.9	116,031	116,031	100.7	100.7	704,726	116,031	100.7	100.7	704,726	116,031	100.7	100.7									
	4 740,839	502,956	64.1	63.4	946,882	949,573	100.3	81.6	142,014	110,410	125.6	125.6	740,839	110,410	125.6	125.6	740,839	110,410	125.6	125.6									
1965	1 716,333	502,999	70.0	70.0	921,932	839,328	91.0	91.0	120,235	118,620	98.5	98.5	716,333	118,620	98.5	98.5	716,333	118,620	98.5	98.5									
	2 739,497	538,518	72.8	71.4	937,689	806,910	84.2	87.6	132,565	123,916	93.4	93.4	739,497	123,916	93.4	93.4	739,497	123,916	93.4	93.4									
	3 743,232	504,049	64.9	69.6	1,016,234	875,490	84.1	87.6	146,275	130,911	93.4	93.4	743,232	130,911	93.4	93.4	743,232	130,911	93.4	93.4									
	4 800,257	506,402	63.1	67.9	1,045,250	1,161,078	110.9	91.5	221,168	228,549	101.4	101.4	800,257	228,549	101.4	101.4	800,257	228,549	101.4	101.4									
	Property - Personal										Property - Commercial																		
	Earned Premium	Incurred Losses	Loss Ratio	Year To-Date		Earned Premium	Incurred Losses	Loss Ratio	Year To-Date		Earned Premium	Incurred Losses	Loss Ratio	Year To-Date		Earned Premium	Incurred Losses	Loss Ratio	Year To-Date										
1964	1 355,410	212,162	59.7	59.7		329,218	212,827	64.6	64.6		376,941	303,327	81.0	81.0		386,245	303,327	81.0	81.0										
	2 376,941	234,801	61.9	60.3		322,161	197,104	63.9	63.9		412,059	347,730	81.4	81.4		412,059	347,730	81.4	81.4										
	3 386,245	240,042	62.1	61.2		347,730	208,274	64.4	64.4		412,059	347,730	81.4	81.4		412,059	347,730	81.4	81.4										
	4 412,059	233,713	56.6	60.0		347,730	269,237	77.4	77.4																				
1965	1 411,489	267,602	65.0	65.0		306,644	235,397	76.7	76.7		416,303	295,126	70.6	70.6		416,303	295,126	70.6	70.6										
	2 416,303	265,164	70.6	68.8		322,194	243,154	75.7	75.7		417,717	263,644	65.0	65.0		417,717	263,644	65.0	65.0										
	3 417,717	263,644	65.0	65.7		329,495	220,449	66.9	66.9		439,394	272,031	65.7	65.7		439,394	272,031	65.7	65.7										
	4 439,394	272,031	65.7	65.7		360,663	234,319	65.0	65.0																				

^aIncludes all
adjustment expense.

CHART 3

Source: Insurers' Advisory Organization of Canada and Statistics Canada,
Consumer Prices and Price Indexes, Cat. No. 62-010.

CHART 4

Source: Insurers' Advisory Organization of Canada and Statistics Canada,
Consumer Prices and Price Indexes, Cat. No. 62-010.

IV CONCLUSION

The analysis in Part A has been complicated by the tangled interaction of the various structural, cyclical and transitory, random economic forces together with the fundamental technological, social and legal changes that all affect the current insurance industry. In unravelling this skein, the Task Force has reached the following conclusions:

First, the heavy concentration of problems in the general liability insurance lines is an unusual feature of this cycle. It has been argued here, and will be argued more fully in Part B, that the general liability area has been the most severely hit by the fundamental structural changes in technology, in societal values and in the practice of civil law that we are currently experiencing. It is therefore on this area of insurance that the Task Force has focussed much of its attention.

Second, a number of longer-term trends have significantly influenced various aspects of risk and insurance and compensation. Thus, although there is no general crisis of price or availability of personal automobile insurance in Ontario, there are clear indications of a trend of increase in the real cost of claims for bodily injury, together with indications of a trend towards a more litigious approach to such claims. These trends have little to do with the insurance cycle, but they have become more visible as the trough of the shift to a hard market has approached.

Third, there are always more difficult and less profitable risks to insure within any given pool, even in sectors such as property insurance or personal automobile insurance. When a hard market appears, the retrenchment nearly always falls more heavily on the more difficult risks within any pool. Many problem areas therefore appear as a by-product of the cycle. Easing those problems will not reverse the cycle. However, neither will a reversal of the cycle correct all the problem areas.

Fourth, even though some of the fundamental structural changes are neither a cause nor an effect of the insurance cycle, the mood of retrenchment in a "hard" market situation inhibits the bold new long-term commitments that may be essential to resolve those fundamental problems.

The analytical focus of the Task Force was based on four sets of questions designed to provide a greater insight into the causes and effects of and possible solutions to the current insurance crisis. The analysis in Part A permits us now to answer these questions:

1. While many industries are characterized by cyclical changes in supply and capacity, why is the instability in the general insurance industry so high?

The explanation for the unusual degree of instability in the insurance industry is twofold. In part, it is due to the highly fragmented nature of the industry. Entry and exit have been all too easy, and the supply of insurance has been volatile and elastic. In part, the instability is due to the unique contingent quality of the insurance product itself. More specifically, the increasing uncertainty surrounding the nature and extent of the liability risks to be insured is making it virtually impossible for insurers to price many products with a reasonable degree of predictability. When the situation reaches the point that insurers feel that they are forced to assume the risk rather than simply pool it, the understandable response is to withdraw or substantially reduce capacity.

Given that markets with high degrees of instability are *prima facie* poorly functioning, changes are clearly required in the insurance industry. The Task Force has considered two basic areas of change.

The first is designed to reduce the excessive structural fragmentation in the industry. This could be accomplished indirectly through increases in the barriers to entry, such as initial capital requirements. This and other suggestions are developed in Part D.

The second proposed change is designed to reduce the uncertainty surrounding the particularly problematic general liability risks, especially as they relate to personal injury compensation. This is discussed in Parts B and C.

2. If the property and casualty insurance industry is as effectively competitive as most scholars and business persons believe, what explains the observation that, in the current hard market, the prices of some kinds of insurance services appear to have increased much more than the record of average cost increases?

This question focuses on the apparently excessive increases in premiums in relation to claims paid out. More specifically, it addresses the question posed by so many organizations to the Task Force about why insurance premiums have increased in one year by over 100% (300%, 500%) when the record of claims has involved small payouts compared with the premiums. The explanation is again related to the extreme difficulty in evaluating so many liability risks, and in anticipating judicial developments in respect of both the parameters of liability and the quantum of damages. It does seem clear, however, that there is an element of overreaction to this situation on the part of the industry. This can certainly be moderated somewhat by an improvement in data bases and by enhancing the availability of accurate underwriting information and of the precise record of experience for particular risks. In addition, the insurance industry must also simply improve its underwriting skills and become more adept in interpreting and analyzing the available information.

3. How can the assertions that 1984 and 1985 were years of large loss ratios for property and casualty insurance companies be reconciled with the evidence of increased prices of listed shares of such companies and with reports of high prices of acquisitions of other companies?

The explanation for this question is fairly clear. It appears that potential buyers of insurance company stocks or of insurance companies saw in 1985 and early 1986 that premium increase decisions were made that, they believed, would lead to rapid increases in premium incomes during the next two or three years. Substantial investment was predicated on the expectation that those increases would exceed the increases in claims incurred. The combination of that expectation and the general bull market in listed stocks have interacted to produce large increases in the prices of insurance stocks. The paradox may be that the combination of increased premium rates and reduced availability of insurance may make the insurance industry much more profitable, precisely at the time when it is coping with fundamental social transformations in the demand for insurance less successfully.

It remains to be seen, however, whether these investors have sufficiently appreciated the unique character of the current cycle.

4. If, as appears to be the case, fundamental structural changes affecting insurance have been underway for many years, why have they only been recognized now?

This question relates to the failure of the industry to recognize and to adapt sufficiently to the fundamental underlying structural changes that have so profoundly altered the current risk environment. The explanation lies in a combination of a number of factors. In part, the failure to respond -- is due to the paucity of comprehensive data analysis of both the current risk environment and the benefit of structural change.

In addition, it appears that the current distribution system involving insurers, brokers and agents, has prevented adequate linkage between the insureds and insurers. The industry has also been slow to adopt technological changes that would enhance this link. Proposals to implement changes in the distribution system are set out in Parts C and D, and should assist in improving the responsiveness of the system.

Above all, however, the failure to respond is due to the inherent inertia of the current insurance system that inevitably precludes consideration of the sort of comprehensive systemic reforms that appear necessary to resolve the current insurance crisis. It is anticipated that the recommendations contained in this report will assist in dispelling this inertia. Moreover, as new financial conglomerates expand into the general insurance industry with more innovative products and services, one can expect to see an acceleration in the pace of change.

P A R T B'

T H E C R I S I S

I N

L I A B I L I T Y

I N S U R A N C E

PART B

THE CRISIS IN LIABILITY INSURANCE

There is no doubt that the current insurance crunch is dominated by a crisis in liability insurance. As noted above, the causes of this crisis are difficult to discern but relate primarily to the extreme uncertainty associated with "long-tail" risks. The insurer's exposure may extend for many years beyond the time when the insured occurrence took place, and systemic socio-legal and economic changes are constantly shifting the parameters of liability and quantum of damage. This uncertainty has made it impossible for insurers to price the various types of risks and has led directly to the severe problems in availability, adequacy and affordability of liability insurance coverage.

This Part will first address the nature and extent of the liability crisis. Next, the variety of responses to the crisis that have emerged on the part of both insurers and insureds will be discussed. Proposals for reforms will then be put forward that are designed to enhance capacity in the more intractable areas where the availability, affordability and adequacy of liability insurance is particularly problematic.

A third section will then review and assess the case for tort reforms. Finally, the concluding section will address the need for a fundamentally different approach to accident compensation.

I THE NATURE AND EXTENT OF THE LIABILITY INSURANCE CRISIS

Background

Liability insurance is the particular type of insurance that has been most affected by the "hard" market. While there are different liability insurance products, the problems are common to each, whether third-party liability coverage under a commercial vehicle insurance policy or various coverages under a commercial general liability insurance policy. Product manufacturers, municipalities, tavern owners, hotels, hospitals, volunteer groups, contractors, truckers, bus operators and newspapers are all exposed to the risk of claims

being brought against them for injuries or damages. The purpose of liability insurance is to protect the insured against many of these risks.

General liability insurance represents approximately 5% of the premiums written by the general industry in Canada, but has generated a disproportionate portion of underwriting losses (some 8.8%). It is all too clear that liability insurance problems are the critical, dominant element of the current crisis and must therefore be addressed on a priority basis. The problems are not just transitory; many entail enduring structural changes.

It is clear to the Task Force that the origin of the crisis lies in the extreme uncertainty that is now associated with underwriting certain liability risks. As insurers often point out, their role is to spread risks, not assume them, -- a role that cannot be fulfilled without at least a minimum degree of predictability. This unacceptable degree of uncertainty is generated by a number of structural sources, which have impacted most strongly on the United States but have also affected Canada:

- (1) The increasing incidence of product liability lawsuits as more complex and potentially hazardous products enter the market.
- (2) The unknown and long-tail nature of many existing environmental risks and hazards generated by a more complex, technologically advanced society.
- (3) The seemingly open-ended and unpredictable court awards and settlements in the United States, particularly for product and professional liability suits -- a trend that insurers expect inevitably to take root in Canada. This applies both to the extent of coverage under an insurance policy as the courts expand the scope of liability to permit compensation effectively on a no-fault basis, and to the quantum of damages.
- (4) The increasing transactions costs associated with the return of the premium dollar to the consumer in the form of claims paid. This applies especially to legal defence costs in connection with the escalating numbers of court awards and settlement referred to in (3).
- (5) The increased propensity of consumers to litigate and the trend toward the so-called "risk-free" society.
- (6) The failure of risk management and risk control and reduction techniques to keep pace with advancing technologies, more complex products and heightened consumer consciousness and expectations.

There are, of course, also cyclical features to the liability insurance crisis. To understand these, a brief sketch of the structure of the relevant segment of the property and casualty insurance industry is required, together with a description of its performance in response to recent internal and external pressures.

Only a few of the many insurers in Ontario have been in a position to handle specialty classes of insureds such as municipalities, professionals, hospitals, buses and long-haul truckers. These insurers tend to be the smaller insurers and, owing to the relatively small premium volume in specialty liability lines, are required to spread the risk throughout the world-wide reinsurance market.

But during the heady period of rising interest rates in the early 1980s, many of these insurers became dangerously over-reliant on this reinsurance, and engaged in destructive cash flow underwriting, using investment gains to offset underwriting losses, in order to maximize market share. The adverse consequences of this were not immediately recognized since insureds of all types appeared to benefit from reductions in insurance premiums to unusually low levels.

But by 1982, interest rates began to fall and investment income to decline. At the same time claims were rising in both frequency and size, and liability settlements in the United States in particular were increasing dramatically far beyond those anticipated when the prices for earlier years had been set. In Canada, the loss ratio on liability insurance was over 100% in 1984 and almost 100% in 1985.

Into this rather unstable environment were injected a series of unanticipated international catastrophes such as Bhopal, earthquakes and the hijack of the Achille Lauro. In addition, huge United States court awards and product liability exposure in the asbestos cases increased claims exponentially and cut deeply into reserves. Other major product liability cases also emerged. These developments accelerated in 1984-1985, culminating in the sudden contraction of reinsurance with the expiry of reinsurance treaties on December 31, 1985 -- something that had an immediate and negative impact in almost all areas with the possible exception of personal property insurance coverage, which has only a small liability component. It has been estimated that overall reinsurance supply dropped by some 50% to 60%.

With the collapse and withdrawal of many offshore reinsurers and the insolvencies of no fewer than five active domestic insurers, the liability market has now shrunk dramatically. Moreover, specialty lines are always the first to feel the effect of the cycle. Most reinsurance treaties are renewed at year end and coincide with the policy renewal time for many organizations. At the end of the calendar year 1985, the restrictions and high cost of reinsurance drove the cost of insurance up dramatically for those who were able to find an insurer willing to provide a market. Insurers took steps to reverse the excessive price reductions in liability insurance that had occurred during the soft market, with the result that, for example, a premium increase of 500% was required to offset a prior premium reduction of 80%. The correction process is now underway and is probably a first step in bringing stability back to the market.

To acknowledge that premiums may have been unrealistically low in recent years is not in any way meant to condone the dramatic swings in premium levels, nor to justify the means by which the cyclical correction is being undertaken. As noted earlier, from the perspective of the insured, any market that gives rise to such swings is unacceptable, and the many cases of negligible notice of non-renewal of coverage or huge increases in premiums have caused widespread public outrage. While the cyclical features of this crisis may eventually work themselves out and premium levels may stabilize, action is certainly required to prevent any repetition of the more egregious developments. Certain recommendations will be put forward in this regard in Part D dealing with the role of government.

Having set out the fundamental nature of the structural and cyclical sources of the current liability insurance crisis, it is useful to turn to an examination of the immediate problems of availability, adequacy and affordability, and their impact on a wide variety of insureds.

Problems of Cost, Adequacy and Availability: Impact on Specific Insureds

In general, insureds are concerned with increased costs, higher deductibles, lower limits, cancellations, restrictive coverage and overall availability of liability insurance. For their part, insurers want a price that covers their anticipated claims and costs, more realistic deductibles and limits,

and greater certainty in assessing risk. Higher claims and settlements both in and out of court, capacity shortages in the primary and reinsurance markets, price competition in the past, lower investment returns, the risk-free expectations of society and liberal interpretation of policy coverage by the courts have all contributed to the present situation.

At the present time, it appears that most entities can obtain liability insurance coverage, although this may require unusual effort. In many cases, the problem is not availability but acceptance of the cost. Insureds that paid a few thousand dollars for a million dollars of coverage in the past when competition for market share led to unrealistically low premiums did not, or could not, easily adjust overnight to much higher premiums. For example, an increase in the annual premium from \$3,000 to \$18,000 is clearly difficult to accept, even though the reasons behind the increase may turn out to be entirely justifiable.

Availability of liability insurance is, however, a definite problem for specific entities. These include many small and medium-sized businesses and many non-profit organizations. Other entities have obtained liability insurance for most risks but have been left facing significant exposures with respect to sub-risks such as pollution and environmental damage. These problems have been partially alleviated in the short term by pools set up with the encouragement of the Province of Ontario and the co-operation of the insurance industry. For example, an association of insurance companies was formed in Ontario to provide liability insurance to small businesses and non-profit organizations that could not otherwise obtain coverage. An earlier pool was formed to provide coverage for pollution risks and risks arising under the "Spills Bill". Special steps have also been taken to extend the Facility Association activities to provide insurance to trucking companies caught by the difficulties of the United Canada Insurance Company and to provide the additional coverage required by those travelling to the United States.

These steps have undoubtedly been somewhat helpful in the shorter term and demonstrate that the parties involved can work together in resolving problems. In the longer term, however, more will have to be done since it is unlikely that the soft markets of the past will return in the near future with respect to liability insurance. More importantly, as already noted, the liability insurance crisis reflects fundamental structural, as opposed to merely cyclical, changes. These require special attention.

It would be useful at this point to set out a somewhat more detailed description of the impact of the crisis on specific insureds who, in the Task Force's view, will require special attention from the government in overcoming the cost and capacity problems. This will then permit a more meaningful assessment of the responses to the crisis and proposals for change set out in the next section.

Manufacturers

Manufacturers in Ontario have faced significant increases in premiums for liability insurance. Many smaller companies were unable to obtain liability insurance before the Ontario Liability Insurers' pool was formed. What liability insurance has been obtained has generally contained higher deductibles and less overall coverage.

A special Canadian Manufacturers' Association survey of members indicated that nearly half of their respondents experienced a doubling of their liability insurance premiums for 1986 and a reduction in coverage. In addition, 30% of the respondents stated that their insurance coverage is inadequate to cover their operations. Finally, substantial premium increases of some 600% to 800% are not uncommon. Particular problems relate to product liability insurance on exports to the United States and to coverage for environmental impairment and sudden and accidental pollution.

Exporters to the United States

Product liability insurance for exports to the United States can be very costly and coverage can be very restrictive. Availability at any price is a major concern. Moreover, many exporters must provide evidence of liability insurance before goods are accepted in the United States. It is interesting to note that similar problems are encountered by exporters from such places as the United Kingdom, Japan and Europe.

Given that more than half of Ontario's gross provincial product is derived from exports of goods and services to the United States, mainly by small and medium-sized businesses, it is clearly of critical importance to ensure access

to adequate and affordable insurance in order not to restrain exporting activity. As noted later, this is likely to require careful assistance from governments, with a view to avoiding any semblance of subsidization that would invite countervailing action in the United States.

Day Care Centres and Similar Facilities

The problems in respect of these insureds appear to have originated in the United States with allegations of injuries from poor-quality care and of child and sexual abuse. Insurers now consider these facilities to be vulnerable, and the market has retracted notwithstanding the fact that Canada has no experience of liability claims for child abuse in day care centres. Policies may now specifically exclude claims for damages for such abuses.

In Ontario, the Day Nurseries Act requires each day nursery or private-home day care agency to maintain in force a comprehensive general liability policy. Many day care centres have been forced to resort to the Ontario Liability Insurance pool in order to continue in business.

Truckers

Problems in the trucking industry were widely publicized during the United Canada crisis. Truckers have traditionally been underwritten by a few specialist companies (one of which was United Canada), and few other underwriters had the experience or interest to step in to fill the gap. The insurance industry responded quickly by opening up the Facility Association to commercial vehicles (including trucking into the United States) and by providing higher limits (\$5 million U.S.) where required. Despite this step, truckers are finding that the current insurance market is very tough and expensive and that there is little adequate coverage available. Particular problems are associated with liability insurance for environmental impairment and sudden and accidental pollution.

Bus and Transit Operators

Bus and transit operators were also hit hard by the tight market. Very substantial premium increases, in some cases ranging from 1,000% to 2,000%,

and reduced coverage were commonplace. School bus operators in particular have little ability to absorb the additional cost, and the ultimate burden will inevitably fall on school boards and municipalities.

Municipalities and School Boards

Liability insurance problems affecting municipalities and school boards are particularly severe. Threatened cancellations of recreational activities, stories of municipalities and school boards going "bare" have been common. Given the implications to the Province of Ontario, it is assumed that the government has provided, and will continue to provide, direction and assistance to municipalities and school boards. As discussed later in this Part, reciprocal and inter-insurance exchange arrangements may offer a longer-term solution. In addition, the interim report of the Municipal Insurance Advisory Committee provides a valuable analysis of the problems and possible directions for change. The recommendations are summarized in Appendix 18 under "Municipalities". The final report is expected in September.

Professionals

Professionals such as architects, engineers, doctors, nurses and chartered accountants are also encountering severe problems in obtaining liability insurance or are facing premium hikes, some as much as several hundred per cent. The particular difficulties of professionals and the proposals for reform are succinctly set out in a special paper prepared for the Task Force that is attached herewith as Appendix 10.

Directors and Officers

Adequate liability insurance for directors and officers (D&O) is virtually unavailable. It seems that there are currently only two main sources of D&O insurance left in North America: American International Group in New York and Encon Insurance Managers Inc. in Ottawa. One firm with no claims history had its liability limit cut from \$75 million to \$15 million over two years and its premiums raised from \$60,000 to \$650,000. In March, it was reported that two directors of a petroleum company in Calgary who were based in the United States resigned, citing a lack of coverage. For \$5,000 to \$6,000 in directors' fees, continuation of service was simply not worth the risk.

Volunteer and Charitable Organizations, Sports and Recreation Groups

Volunteer and charitable organizations such as the St. John Ambulance and the Red Cross have faced dramatic premium increases or indeed instances of total non-availability of liability insurance for their volunteers. Eventually they found limited coverage for their volunteers but at premium levels several hundred percent higher than for the preceding year.

Liability insurance costs for sports and recreational groups have risen from 150% to 900% for both provincial and community-based organizations. A survey conducted by the Ontario Sports Medicine and Advisory Board determined that more than 55% of the municipalities surveyed no longer provide liability coverage for community groups using public facilities. Reports of activities being terminated by reason of lack of insurance have been common.

Insurers point to high court awards in the United States and to the high legal cost of defending even frivolous claims, while the insureds argue that the increase in premium rates and the reduction of coverage have no apparent relationship to the history of the claims against the insured. For example, the number of claims filed against provincial sport and recreation organizations over the last three years appears to be less than 10, with an average settlement of less than \$1,000. Unfortunately, however, two recent claims have initially been listed at \$3.9 million and \$1 million respectively -- something that insurers obviously consider in establishing the new premium levels, even if the claims are not ultimately successful.

Hospitals

Hospitals face a 362% increase in the basic cost of liability insurance in 1985-1986. The percentage of the total provincial hospital operating budget spent on liability insurance premiums increased from 0.093% or \$3.5 million in 1983-1984, to an estimated 0.947% or \$41 million in 1985-1986. Increasing litigation is obviously a significant factor in the problems of cost and availability. Statistics compiled in respect of doctors are useful in this area. The number of doctors involved in litigation in Canada has increased from 516 in 1982 to 1,266 in 1984 and to over 1,500 in 1985, and in Canada the total amount paid out by the Canadian Medical Protective Association, which insures over 85%

of doctors, rose from \$5.96 million in 1982 to \$13.78 million in 1984. Most of these malpractice suits involve both the physician or surgeon and the hospital in which the medical act occurred (and often involve complex issues of the allocation of responsibility between the hospital and the doctors).

The availability of liability insurance for hospitals is now severely limited, and there is no longer a truly competitive market. Only two major insurers remain: Scottish & York, the insurers of the Ontario Hospital Association's Comprehensive Insurance Program (CIP); and the Guarantee Company of North America, through its brokers, Frank Cowan Company of Princeton, Ontario. As of March 1986, 130 public hospitals out of a total of 350 hospitals and allied health institutions in Ontario (60%) obtained their insurance, including liability insurance, through the CIP. In the current volatile market, the continued provision of coverage is not certain, and the shift to claims-made policies from the occurrences form is likely to take place.

Hospitality and Tourism

All submissions received from associations in the hospitality and tourism industry stressed a problem with cancellations and non-renewals as well as with significant increases in premiums and deductibles. In particular, it was requested that the Insurance Act (Ontario) be amended to require 90 days' written notice to the insured if the insurer intends to:

- o cancel a property or casualty insurance policy;
- o not renew a policy; or
- o raise the premium or increase the deductible.

It was further requested that a notice to raise premiums or deductibles state the amount of the increase.

Taverns

Increased public concern over drinking and driving in the United States as well as in Canada has shifted greater responsibility to the tavern owners and created higher exposure. The increasing frequency and severity of judgments against establishments serving alcoholic beverages have resulted in substantial premium increases, lower deductibles and availability problems. While the situation in Canada is not yet as severe as in the United States, the same trend

toward expanding the scope of liability for third-party injury imposed on tavern owners is very clear.

II RESPONSES TO THE CRISIS AND PROPOSALS FOR REFORM

Responses by Insurers

The primary way in which the industry has addressed the liability insurance crisis is through reductions in coverage, increased premiums, and in some cases the total withdrawal from underwriting in certain areas. This will be discussed with specific reference to claims-made policies, environmental impairment and pollution exclusions, and the treatment of legal defence costs within policy limits.

Claims-Made Policies

Perhaps the most important change in the way liability risks are insured is the development of new commercial policy form -- the claims-made policy. Comprehensive general liability insurance, including product liability coverage, has traditionally been written on an occurrence basis. The fundamental difference between the occurrence form and the claims-made form is the event that triggers policy coverage. In the occurrence form, an occurrence in the policy period resulting in damages covered by the policy triggers the policy coverage, whether or not a claim is filed during the policy period. The key date is the date of the occurrence rather than the date of making the claim. In the pure claims-made form, the key date is the date that the claim is first made. If the claim is made in the policy period, coverage is triggered.

From the viewpoint of the insured, the occurrence form is generally preferable, since the liability for presently unknown occurrences causing injury or damage will be subject to the policy in effect at that time, even if not discovered for many years in the future. The potential for a gap in insurance coverage is therefore minimal, assuming an insurance policy in the occurrence form is in force at all times. One potential problem, of course, is the possibility that the policy limits in effect at the time of the occurrence may prove to be insufficient many years later when the claim is ultimately settled.

The major impetus for the change to the claims-made form was the liability for illnesses with a long latency period or long discovery period and originating from exposure to toxins, drugs or other products, notably diethylstilbestrol (DES) taken during pregnancy, asbestos, etc. It took many years for the deadly effects of asbestosis to manifest themselves, and it took many years before the bodily injury arising in children of women who had taken DES was linked to DES. To provide an extreme example, exposure to asbestos dust in shipyards in 1944 has been judged to be the occurrence that appeared as cancer in the early 1970s and that then gave rise to claims against a company and the insurance contract that was operative in 1944.

According to insurers, the occurrence form for the CGL policy places a significant burden on the insurer to price the policy today without knowing the circumstances that will apply when the policy is triggered in the future. What product-induced diseases will surface many years from now, especially since major scientific and technological advances are leading to the development of many new complex products and processes that may have significant health-related repercussions in the future? How will the courts interpret the policy at that time? The courts, particularly in the United States, are continually redefining and expanding the meaning of "occurrence", with the result that insurers are exposed to losses never contemplated at the time the premium was set. For example, with respect of the asbestosis claims in the United States, "bodily injury" has been interpreted to mean any part of the single injurious process that asbestos-related diseases entail. Hence there is more than one trigger and more than one policy applying to the same claim, thereby permitting the policy holder to select at will any of the insurers involved over the years to defend its claims and compensate for damages.

The insurance industry asserts that one of the primary purposes of the claims-made form is to ensure that only one policy and one limit apply to a single loss -- the policy in effect at the time that the claim is made. In its submission to the Task Force, the Insurance Bureau of Canada has noted that "the introduction of a claims-made version of the CGL allows for precision in determining the coverage period, avoids the stacking of limits and policies that now occurs and avoids costly litigation over policy application". Under a claims-made policy, an insured must inform the insurer as soon as possible after an incident has occurred. But this does not yet trigger the responsibility of the

insurer. This occurs later, when a full claim is formally and legally registered. This gives rise to the problem of "tail" coverage. For example, consider an insurance contract for the calendar year 1986: an incident occurs in late November and the insurer is notified by the end of November. But the preparation and registry of a claim may take some months. In what period of time can claims be made against the 1986 insurance contract? On what terms will 1987 insurance contracts be available?

The details of the various forms of claims-made policies that are currently in use or entering into use in both the United States and Canada are set out in a useful paper prepared for the Task Force on Insurance by the consulting firm of Woods, Gordon. The Task Force expects the paper to be of interest to a wide range of insurers and insureds. It would be useful at this point to highlight the problems arising in respect of the claims-made policy, and the ways in which these may be addressed.

To begin with, the Task Force acknowledges that in many ways the public must accept the need to change to the claims-made policy if insurers are to continue to write liability insurance and survive over the longer term. But many legitimate concerns have been raised with respect to the new form that must be addressed by both the insurance industry and the regulators.

The two major problems with the claims-made form can be summarized as follows:

- (1) possible absence of insurance coverage due to gaps in time, restrictive coverage or inadequate aggregate limits; and
- (2) pricing and obtaining "tail" coverage.

These two problems arise due to certain provisions in the "standard" claims-made policy form, and, in particular:

- o the coverage trigger;
- o the retroactive date: for example if the retroactive date is advanced, a gap in coverage will exist between the date of the last occurrence policy and the new retroactive date;
- o the sufficiency of automatic tail coverage: the IBC recommends only a 60-day minimum period within which an insurer is prevented from cancelling a policy after an incident that might

cause a claim is reported, but before the actual claim is registered (the automatic tail has two parts -- the mini-tail to allow late reporting of an incident or claim and a longer tail to provide coverage (and prevent cancellation) for the anticipated losses from known incidents reported to the insurer.)

- o the sufficiency and cost of the supplemental tail coverage that applies to incidents reported to the insurer more than 60 days after the expiration of the policy and claims filed more than five years after the expiration date for incidents reported within 60 days (i.e., those falling outside the automatic tail). Concern has been expressed that the standard premium for the supplemental tail will be 200% and will include the full premium for the policy rather than the appropriate portion of the premium for the coverage to which the endorsement applies (e.g., bodily injury);
- o laser endorsements: the IBC standard claims-made policy includes endorsements that restrict coverage rather than expand it, with a view to providing greater flexibility with respect to the definition of insurance needs at a more efficient premium cost. But there is a danger that an uninformed insured will not be aware of the implications of the endorsement and that the insurer will force them on the insured, thereby giving rise to gaps in coverage and the need to purchase tail coverage for a product or incident, or simply "going bare" for that liability.

In addition to the foregoing, concerns of a general nature relate to the fact that the claims-made form is far more complex and requires much greater knowledge on the part of the insured. This is particularly important since, in effect, the insurer is shifting part of the underwriting risk to the insured by requiring the insured to define coverage needs more precisely. Three general concerns can be singled out:

- o lack of knowledge on the part of both insureds and brokers, leading to a lack of appropriate coverage and protection.
- o greater opportunity for insurers to restrict coverage; and
- o blanket use of claims-made forms in all cases even if not warranted by the nature of the risk.

To address these concerns, the Task Force recommends that:

B.1 The industry should take immediate steps to ensure clear and timely explanations of the scope and application of the claims-made policy are provided to insureds directly, and through brokers and agents.

In this connection, it must be noted that the Insurance Bureau of Canada has already organized seminars, information briefings and so forth. But given the severe communications problems between insured and broker and

between broker and insurer arising from the current distribution system mentioned above, the Task Force believes that the education effort in this area must be greatly enhanced.

The Task Force also recommends that:

- B.2 The Superintendent of Insurance should be accorded wider powers of regulation in respect of the approval of commercial general liability policy forms, with a view to imposing minimum standards and to preventing potential abuse of the claims-made form by insurers.
- B.3 The Government of Ontario should undertake a review of all statutes requiring minimum commercial general liability insurance coverage to determine if any additional provisions are required in the case of a claims-made policy form, such as mandatory tail coverage.

This should involve the introduction of "statutory conditions" in the Insurance Act to deal specifically with the claims-made policy form. Such conditions should set out, for example, the circumstances in which the retroactive date can be advanced or tail coverage applied. In addition, the Task Force is concerned about the apparent trend to adopt the claims-made form for all commercial risks, and would expect the superintendent to ensure that its use is restricted to the open-ended, long-tail, unpredictable liability risks.

Finally, the Task Force recommends that:

- B.4 Specific attention should be given to the claims-made policy form in establishing regulations with respect to minimum notice periods for non-renewals of coverage, mid-term cancellations and changes in coverage. (See Recommendation D-29.)

Environmental Impairment and Pollution Exclusions

Owing to a combination of new legislation reflecting the intensified public concern with environmental risks and hazards, judicial interpretations of policy language, and the inherent uncertainty surrounding an increasing number of such risks and hazards, the availability of insurance coverage for "sudden and accidental" pollution has shrunk considerably, while coverage for environmental impairment and longer-term pollution risks has virtually dried up. Indeed, the claims-made commercial general liability policies of both the Insurance Bureau of Canada and Lloyd's of London specifically exclude pollution coverage.

The new legislation is Part IX of the Environmental Protection Act, which was proclaimed in force on November 29, 1985. This imposes strict liability for environmental waste discharges on both owners of substances that pollute and persons in control of substances that pollute (e.g., carriers). The so-called "Spills Bill" requires such owners and controllers to finance the clean-up and restoration costs, as well as satisfy other property damage claims, bodily injury claims and pure economic loss claims.

The insureds most affected by the capacity and availability problems in respect of pollution coverage are the primary producers and distributors, such as oil companies, service stations, chemical producers, manufacturers and distributors and carriers of potentially hazardous products (such as PCBs). In addition, great concern has been expressed over potential liability exposure by those industries that have voluntarily taken steps to deal with pollution events in an emergency. These include the petroleum industry's land spill co-operatives and the Petroleum Industry Marine Environmental Co-op of Ontario (PIMEC), as well as the Canadian Chemical Producers' Association's Transportation Emergency Assistance Plan (TEAP). (Most road carrier risks are still covered by the standard automobile policy.)

The Ministry of the Environment has also expressed concern over the inability of pesticide operators licensed by the Ministry to obtain the necessary liability insurance mandated under the Pesticides Act. Similar difficulties are being encountered by operators of waste management systems and waste disposal sites, including the Ontario Waste Management Corporation in respect of its handling and disposal of hazardous waste.

In response to the crunch, the Government of Ontario, acting initially with the Insurance Bureau of Canada and then with approximately 25 Canadian insurers, was instrumental in creating the "Limited Pollution Liability Insurance Pool," or "Spills Pool", now administered by Insurers' Advisory Organization. Its terms of reference include providing sudden and accidental pollution coverage only for those risks with relatively minor pollution exposures that are unable to obtain pollution coverage within the CGL policy. Endorsements are issued for limits up to \$1 million. Limits in excess of this amount are recoverable from the Environmental Compensation Corporation established within the Ministry of the Environment pursuant to the "Spills Bill". At present there are seven categories

of risks ranging from basic retail stores to chemical manufacturers. Some insurers have now realized that the potential for losses in the lower categories are remote and are now opting to insure up to the first four categories without seeking the pool's reinsurance.¹

Nevertheless, it is all too clear that the Spills Pool coverage is limited and that, effectively, the government is potentially on the hook for the payment of tremendous claims. A few of the specific concerns with the inadequacy of the protection are as follows:

- o Service stations in particular are exposed to liability owing to the exclusion for bodily injury, property damage or clean-up costs caused by a pollution incident originating below the surface of the ground or water and then subsequently exposed by erosion, excavation or other means.
- o A fuel spill from an unlicensed fork lift truck may be unprotected owing to the exclusion of pollution coverage from self-propelled motor vehicles. (Unlicensed vehicles cannot obtain the usual coverage pursuant to SPF#1 under the automobile policy.)
- o Third parties suffering bodily injury may not be adequately compensated because of the low policy limits and the priority accorded to clean-up costs and defence expenses.
- o Insurers may well react by reducing third-party automobile SPF #1 limits to \$200,000 minimum mandated by statute, and then issuing an excess policy with a pollution exclusion. In addition, they may refuse to write non-owned automobile SPF #6 insurance in order to avoid being dragged into actions.

In light of the foregoing concerns over the lack of availability and the inadequacy of coverage for environmental impairment and "sudden and accidental" pollution, the Task Force recommends that:

- B.5 Consideration should be given to requiring the companies engaged in environmentally hazardous activities to set aside reserves to cover potentially catastrophic pollution events. Such reserves should be tax-exempt (see also Recommendation D.37).
- B.6 The Government of Ontario should take steps to encourage the formation of an industry-based pool to accommodate currently uninsurable risks such as leaks from underground storage tanks involving fuel at service stations, home heating and oil, and industrial storage of fuel and other raw material and products.

¹ Note that the farm mutuals have continued to provide both environmental impairment and "sudden and accidental" pollution coverage to agricultural producers at reasonable cost.

- B.7 The Insurance Act should be amended to make clear that insureds such as oil companies are permitted to indemnify members of their sales associate network and other non-affiliated companies and contractors in the event they suffer losses for which insurance protection is either unavailable or prohibitively expensive such as coverage for underground tank leaks and other pollution-related exposures.
- B.8 The Superintendent of Insurance should work with the insurance industry to develop adequate provision for "sudden and accidental pollution coverage" within the Comprehensive General Liability policy, and if necessary, address the problem by way of minimum statutory conditions.

Legal Defence Costs

Until recently, the costs of defending against liability claims were not included within the aggregate limits of the CGL policy. Insurers traditionally controlled the defence costs by hiring their own lawyers to conduct the defence. The insurers then paid all the costs, and the full amount of the policy limits was available to pay any settlement or judgment against the insured.

Since the late 1970s, however, defence costs have escalated and, with a view to controlling costs, the insurance industry proposes to include defence costs within the aggregate limits of the policy -- a practice that has already been incorporated in some other policy forms. This approach has been incorporated in the new claims-made policy form.

Obviously concerns have now arisen that in some cases defence costs may exceed the policy limits and leave nothing to satisfy the settlement or court award. Defence lawyers may also urge settlement in inappropriate cases simply in order to prevent defence costs from consuming all available coverage.

In the United States, the ISO has proposed limiting defence costs to 50% of the aggregate limit, but the National Association of Insurance Commissioners has urged states not to approve the ISO proposal until the proposal can be studied by the commissioners.

The Task Force is likewise concerned with the implications of such developments in respect of defence costs and recommends that:

- B.9 The Superintendent of Insurance should examine the treatment of defence costs under the Commercial General Liability policy and,

if necessary and appropriate, make recommendations to the government for appropriate action to enhance the protection of the insured.

Responses by Insureds

The current market has caused many organizations to examine closely the cost of liability protection and the alternatives that might be available. This cost includes actual insurance premiums paid to outside insurers, self-insured losses (e.g., deductibles and captives), loss prevention expenses and associated administrative costs.

Each one of these components had to be addressed, but one of the most important management decisions was the extent to which risk was to be retained by the organization in the form of deductibles or restrictive coverage. The acceptable exposure on any one particular risk had to be considered as well as the total exposure on all risks. Changing retention and exposure levels affected each cost component mentioned above.

Following the review of costs and current and anticipated market availability, some organizations may simply decide to accept higher premiums, increased deductibles and reduced coverage. For example, in 1985 one Canadian utility paid \$18,000 for \$2,500,000 of primary coverage under a general liability policy. The company's assets and retained earnings were substantial. The only quotation received for 1986 was \$46,000 for \$1,000,000 of primary coverage. In this case, the increase in premium was meaningless in relationship to income, assets and gross revenue. Nor was the reduction in primary coverage of great concern. In summary, this company noted that premiums had more than doubled in one year but accepted the increase.

Many companies likewise adapted to the new pricing and terms. Even though premiums have increased significantly from a percentage point of view, the actual cost in dollars has not warranted serious review of alternatives. The premium cost and increased exposure continues to be immaterial to the company. Based on a small, but probably representative sample of companies in this position, premiums for liability insurance renewals represent less than 1/5 of 1% of before-tax income.

At the other extreme, however, many organizations have found the increased premium cost and exposure to be very considerable. For example, one Ontario manufacturer of a product considered to be high-risk by insurers and exported to the United States had to increase the selling price of its product by more than 40% just to cover the increase in liability insurance related costs. Product liability insurance costs and exposure to product liability suits are the major financial concern to the company and a threat to its very existence.

Many organizations fall between the two extremes. The increased cost and exposure are significant but not devastating. The anticipation of a continued tightening in the market and the possibility that adequate coverage may not be available at any price are ongoing concerns.

Organizations in this position have investigated alternatives to the "normal" commercial general liability policy. These alternatives include captive insurers; retrospectively rated premiums (i.e., based on actual loss experience); group, industry and association pools or captives; administered fund arrangements; claims-made policy forms (as opposed to occurrence form of policy); higher deductibles; and lower aggregate limits. In most cases, the alternatives examined require greater risk retention by the organization and, consequently, loss prevention has become much more important.

Unfortunately, there are certain obstacles to many of these alternatives. The "single-parent" captive-insurer approach faces three major problems -- taxation, legislation and aggregate stop-loss reinsurance. Following the Consolidated-Bathurst Limited case, there is now considerable doubt as to the deductibility of the premium paid to the captive for Canadian tax purposes unless the captive is a bona fide insurance body with separate management. Furthermore, amendments to the foreign affiliate rules in the Canadian Income Tax Act have removed many of the advantages of using offshore captives located in tax-haven jurisdictions by taxing certain income as earned (rather than as received). Statutory capitalization and other requirements under both the Ontario and federal insurance acts effectively preclude a company based in Ontario or Canada. Even if these problems can be resolved, aggregate stop-loss reinsurance to cap losses in the captive are generally not available.

Retrospectively rated premiums certainly make sense, but the concept has been abused, transferring very little real risk and becoming highly questionable from a tax point of view. These arrangements have not generally reduced exposure, and many are intended to address the problem of tax deductibility with respect to self-funding.

The formation of group, industry and association captives is equally problematic, even if they are properly structured and independently managed so that the tax problems can be resolved. The reinsurance availability problem still remains. But the most difficult problem encountered is the reluctance of the members to actually share each other's losses and the reluctance to transfer real risk among the participants, particularly where the members compete openly in the same marketplace. A group captive structured as a number of individual cells where no risk is transferred does little to reduce exposure and, if carefully examined, does little from a tax point of view. To date, few group captives have actually been set up by Canadian organizations, and those that have been formed are usually offshore, given Ontario and federal capitalization requirements.

Buying or arranging insurance through a trade association or group has certain advantages and is currently being investigated by many organizations. Some companies have decided to "go bare" (i.e., without insurance) or be underinsured. A few of these companies have stripped assets from their limited liability companies in an attempt to limit losses should financial failure result from large claims. Others have considered segregating higher-risk activities in another corporation (which could be abandoned if adverse circumstances arise).

Organizations unable to obtain mandatory minimum levels of liability insurance coverage in order to operate are considering arrangements that provide the required coverage for a premium slightly in excess of maximum exposure under the policy (i.e., the million dollar premium for the million dollar coverage). This allows the insured to produce a liability policy and continue to operate, but little else. These policies are clearly expensive given the meaningless value of the policy, and most insurers have been very reluctant to become involved with these arrangements. But some pressure has been put on insurers by brokers on behalf of uninsureds, in order to provide a policy to allow the organization to continue to operate while the broker tried to find a more conventional policy.

Some companies have found success by changing agents or brokers as the new agent or broker may have had access to different underwriters. This reflects the accessibility problem discussed in Part C in respect of the distribution system.

In most cases, there has been an attempt to balance the cost of the policy and exposure on self-retention (generally in the form of a higher deductible). As a general rule, the higher the self-retained risk (or deductible), the lower the premium. In the soft markets of the past, deductible levels may admittedly have fallen too low. In the current market, a much higher deductible may be warranted from an overall cost point of view. But if the deductible exposes the insured to too great a risk, consideration must be given to the creation of a facility to share the risk on the increased deductible with others in a similar position. This and other new mechanisms will be discussed later.

Developments in the United States

Problems similar to those in Canada occurred in the United States long before they surfaced here. Liability insurance coverage for municipalities, health care entities (including day care centres and nursing homes) and taverns is difficult to obtain in the United States.

The insurance industry in the United States is subject to regulation by the individual states. In an effort to deal with the availability and affordability crisis, individual states immediately acted to assist industry groups in finding coverage. Critics' initial demands for federal regulation of the insurance industry were somewhat suppressed by these actions. Although the efforts of individual states helped to alleviate the availability problem in the short term, it was felt that further action was necessary to solve the availability and affordability crisis in the long-term, perhaps through federal action. Steps are currently underway to increase capacity through amendments to the federal Risk Retention Act of 1981. The amendments would make it simpler for businesses, trade groups and municipalities to form captive insurance companies or pools and/or purchase liability insurance as a group.

As a first step to deal with the lack of insurance coverage many industries were facing, some states passed new regulations with respect to non-

renewals and to prevent insurance companies from cancelling policies in midterm without adequate notice. Critics, however, felt that such actions would make insurers more reluctant to write risks in those states, and would cause some to leave states, and thereby adding to the lack-of-capacity problem. One state proposed legislation that would allow it to regulate property and casualty insurance rates and vowed to push it through this spring. Another state granted immunity from civil suits to taverns selling liquor to a person who subsequently injures another while impaired. Most states have established voluntary market assistance programs to help industries and municipalities find insurance where coverage is not available. Such programs have been very successful.

The federal government is currently reviewing a wide range of federal product liability and tort reform bills and, most recently, the "Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability", submitted in February 1986. This report has concluded that developments in tort law are a major cause for the sharp premium increases for liability insurance. Four particular areas of concern were singled out for special attention:

- o The movement toward no-fault liability, which increasingly results in companies and individuals being found liable even in the absence of any wrongdoing on their part.
- o The undermining of causation through a variety of questionable practices and doctrines that shift liability to "deep pocket" defendants, even though they did not cause the underlying injury or had only a limited or tangential involvement.
- o The explosive growth in the damages awarded in tort lawsuits, particularly with regard to non-economic awards such as those for pain and suffering, or punitive damages; and,
- o The excessive transaction costs of the tort system, in which virtually two-thirds of every dollar paid out through the system is lost to attorneys' fees and litigation expenses.

This issue of tort reform and its applicability in the Canadian context will be addressed in detail in sub-part III below.

Proposals for New Facilities and Enhanced Capacity

The following discussion will set out a series of new mechanisms and other reforms designed to enhance capacity in the critical area of liability

insurance. The implementation of proposals involves no changes or only modest changes in legislation. The Task Force wishes to emphasize that, in putting forward a variety of recommendations, it is not expressing a particular preference for one mechanism or another, unless otherwise indicated. Clearly, the suitability or propriety of each will depend on a variety of factors such as the nature of the participants and the risk to be insured.

Several preliminary observations are perhaps useful. Firstly, it is preferable for the insured to stay within the insurance system rather than go offshore. Otherwise there will be no benefit from the Superintendent's regulation, and the risk base in Ontario will be diminished, thereby reducing the effective pooling of risks so critical to the insurance mechanism. Secondly, as a general matter, it is desirable to promote a healthy insurance industry in Ontario. Finally, self-insurance programs must be monitored closely, since an ill-conceived plan may endanger the financial position of both individuals and business organizations and provide inadequate protection to third parties.

Reciprocals

Reciprocal insurance exchanges are an important mechanism for generating additional capacity and can be implemented pursuant to Part XIII of the Insurance Act. Such an exchange is an unincorporated group or pool of individuals or organizations that contract with each other to spread the risk and losses inherent in their activities.

If one member suffers a loss, the others contribute toward the payment of that loss, based on a pre-agreed formula. The members, usually called subscribers, traditionally cover any losses by paying some premiums up-front, and agreeing to be assessed for the amounts in excess of that premium. The exchange is accordingly a form of mutual insurance that can be attractive to certain groups of organizations who have certain activities in common. It is limited to property and casualty insurance.

Very few such organizations ever existed in Ontario, probably because until recently, reasonable insurance was available. There is, however, increased activity in the formation of such exchanges at the present time.

A special report on reciprocal insurance exchanges has recently been prepared by the Financial Institutions Division of the Ministry of Consumer and Commercial Relations. Entitled "How to Set up a Sound Reciprocal Insurance Exchange", it deals specifically with publicly supported organizations such as municipalities and hospitals.

The Task Force believes that commercial enterprises should likewise be encouraged to establish reciprocal insurance exchanges. An exchange, for example, might be the most appropriate vehicle with which to ensure higher deductibles in particularly problematic areas such as libel and slander insurance coverage for newspaper publishers.

The Task Force recognizes, however, the problems arising from confusion over the tax treatment of such reciprocal exchanges. There appears to be a general lack of understanding of the true legal nature of a "reciprocal insurer" involving an unincorporated entity, subscribers and the attorney-in-fact. In addition, the taxation of the exchange (i.e., who is taxed and how) is frequently subject to inconsistent administrative application by the tax authorities.

The Task Force therefore recommends that:

- B.10 The Superintendent of Insurance should continue to encourage the establishment of reciprocal insurance exchanges in appropriate cases, and should prepare a booklet describing the nature of reciprocal exchanges, their potential advantages and the statutory requirements under the Insurance Act designed more specifically for commercial entities.
- B.11 The provisions of Part XIII of the Insurance Act should be updated and clarified with respect to the obligations of subscribers or members of reciprocal exchanges.
- B.12 The Superintendent of Insurance should request a ruling from Revenue Canada on the taxation of reciprocal exchanges and make available a commentary prepared by Revenue Canada to interested persons.

Insurance Pools

As noted above, groups of insurers have recently banded together to form pools as a means of providing coverage for difficult-to-place liability risks.

The first such pool was created in November 1985 to provide coverage under the newly proclaimed Environmental Protection Act. It is known as the Spills Pool and has over twenty subscribing insurers. The pool has a common rate manual, and all subscribing insurers join in the insuring agreement. Coverage is restricted to \$1 million.

In January 1986, because of difficulties in placing certain liability coverages, an additional pool was created. The OLI pool consists of some 25 companies banded together in a subscription policy arrangement to provide coverage to small businesses and non-profit organizations. It provides up to a maximum of \$1 million per incident and a total annual limit of \$1 million. The broker referring the business is paid a 5% commission. The OLI pool was intended as a temporary arrangement to deal with transitory difficult problems under "hard-market" conditions.

There is no doubt that this pooling mechanism and, more generally, the Market Assistance Program has proved invaluable in addressing the problem of availability for many volunteer and non-profit groups and small and medium-sized businesses exporting to the United States. It has not and cannot, however, address problems of affordability and adequacy. Nevertheless, some pools should be viewed as potentially valuable longer-term instruments to be used, albeit for limited purposes, in difficult areas of liability insurance coverage.

There is no legislative amendment necessary to prohibit or inhibit the establishment of further or additional OLI pools, as the occasion may arise. The insurance industry accordingly has the capability to maintain and operate such pools, until such time that acceptance of risks by individual companies is resumed. It may well be that the pools will be disbanded, or certain risks can be taken from the pools. Undoubtedly, the experience of the OLI pool will dictate its future need or change in operation.

Mention should also be made of the other pooling-related efforts on the part of insurers to expand capacity and fill in gaps in availability in other areas. For example, joint underwriting has been facilitated by the formation of the Canadian Industrial Risk Insurance (CIRI) Association. The Canadian Industrial Risk Insurance Association was formed in 1973 by 30 stock insurance companies to provide a facility for wide participation of Canadian insurers in a risk-sharing

mechanism that emphasizes co-operation in loss reduction services. By 1979, it ranked among the top 15 groups in Canada writing property and casualty insurance. In addition to the Canadian Industrial Risk Insurance Association, there is the Factory Mutual System, consisting of three insurance companies that provide a similar facility. Such industry mechanisms are clearly valuable and must be encouraged.

The Task Force believes that ad hoc industry-based insurance pools have proved valuable for addressing capacity crunches and will likely continue to be necessary for the most difficult liability risks as they emerge. Moreover, based on the positive record of the Market Assistance Program and the hot-line service, it is clearly preferable to restrict the government role where necessary to that of animator and facilitator. In this connection, the Task Force does not recommend that the government opt to mandate joint underwriting associations in certain lines, as various U.S. states have done in respect of medical malpractice.

Nevertheless, a somewhat stronger government role may be required in special cases. For example, the case of the recent greenhouse disaster demonstrates that the government itself may have to step in as the reinsurer of last resort where the industry capacity is simply not available and public interest so dictates. The ever-increasing number of environmental risks, nuclear power hazards and other possible catastrophes clearly fall into this category as well.

The Task Force therefore recommends that:

- B.13 The insurance industry should be encouraged to continue to adopt pooling measures as required from time to time.**
- B.14 The Government of Ontario should continue to be prepared to act as the facilitator of industry-based insurance pools when capacity crunches emerge from time to time.**

Export Liability Insurance Pool

As noted earlier, the Task Force believes that there are compelling reasons to justify a stronger government role in assisting the insurance industry to meet the demand for liability insurance for exports to the United States. The deep concerns in this area were highlighted in a letter to the Task Force from the Honourable Hugh P. O'Neil, the Minister of Industry, Trade and Technology:

Clearly, we cannot continue to have the success of some of our more competitive firms jeopardized by the lack or high cost of insurance. This results in the loss of exports and jobs. It is impossible to estimate the potential losses but they could be substantial. Given that the problems are not amenable to early solution, consideration should be given by the Task Force to what measures can and should be taken both by the insurance industry and government. In this regard, it may be possible for groups of insurance companies to pool product liability risks, especially for exporters to the United States. This is unlikely to reduce the affordability of coverage. To be successful, such an initiative might have to be supported by government involvement. In this case government could either assume a portion of the pooled risks or provide limited reinsurance, without any element of subsidy, to the insurance pool. The Task Force should also consider what can be done to further develop an Ontario-based reinsurance industry.

The Ministry of Industry, Trade and Technology recommends therefore that the Task Force give high priority to the insurance problems confronting Ontario businesses, especially in the area of product liability insurance for exports to the United States. There is an urgent need to deal with this crisis, and we urge you to consider immediate measures, as well as the long-term social and institutional changes which may be necessary.

The Task Force believes that the pooling mechanism might be most effective in addressing the availability, adequacy and affordability concerns in this area. It is important, however, to consider the implications of any government action for Canada's commitments under the General Agreement on Tariffs and Trade, and the need to avoid any semblance of a subsidy, since this would simply invite immediate countervailing action by the Americans. In addition, the Task Force is of the view that any action should take a national rather than a narrowly Ontario point of view. Efforts should be made to involve the federal government, particularly since many exporters operate beyond the boundaries of Ontario. However, in view of the importance of such insurance to the Ontario economy, if federal action is not forthcoming, Ontario should help create the required facility, which could serve Ontario and broader national interests as experience develops.

The Task Force considered the possibility of using the Export Development Corporation (EDC) as the appropriate vehicle for a government role. The purpose of the EDC is to provide financial services to Canadian exporters. At present, the EDC role is primarily credit- and performance-related, and does not involve product liability insurance. The Task Force has concluded, however, that the EDC vehicle is not appropriate, given the high probability that its activities would be viewed as unfair trading practices.

Other options include a direct government facility (federal or provincial); a government-sponsored pool; a pool sponsored by the insurance industry; and an export industry pool. The Task Force is pleased to learn that the government has already been examining such options on an urgent basis. It would seem appropriate to try to tailor the option to minimize the direct government role and therefore the chances of being accused of illegal subsidization under GATT. The Task Force therefore recommends that:

- B.15** The Government of Ontario should give strong consideration to sponsoring an insurance industry pool, the terms of reference of which will be carefully drawn up so as to restrict assistance to those exporters experiencing a severe availability, adequacy and affordability crunch, and to avoid any appearance of subsidizing inefficient producers and manufacturers. The pool should be administered by the industry and include a hot-line service. Government financial assistance might be provided by way of reinsurance of the last resort, or guarantor of retrospective rates and excess losses when the capacity even within the pool proves inadequate and where the situation so demands in accordance with prearranged guidelines.

New Mutuals

The Corporations Act of Ontario provides for the incorporation of mutual or cash mutual insurance corporations that can be licensed under the Insurance Act. The mutual insurance corporation is probably one of the first examples of corporate co-operative legislation. It operates on the principle that each member who is insured is entitled to one vote. Capital requirements and rules of operating are the same as for a joint-stock insurance company licensed in Ontario.

It is therefore a viable alternative to individuals or corporations who have a common goal in securing liability insurance and are concerned about the lack of limited liability associated with a reciprocal insurance exchange.

The Task Force therefore recommends that:

- B.16** The Superintendent of Insurance should ensure that greater information on the possibility of creating mutual or cash mutual insurance corporations as viable mechanisms for expanding capacity, be provided to the public.

Expansion of Farm Mutuals

There are some 51 farm mutuals licensed under the Insurance Act, many of which have been in existence for over 100 years. They provide insurance to nearly 85% of the farms in Ontario. The farm mutuals are well organized, with their own reinsurance plan and with a guarantee fund to protect their insured members from insolvencies.

Mutuals originally wrote only fire and lightning insurance for their members. Since the 1950s, their underwriting has extended to include various other perils and eventually liability insurance. They now provide automobile insurance and environmental protection insurance to their members.

By reason of safe investment strategies, farm mutuals have built up a considerable surplus -- in the order of \$150 million.

The Task Force believes that one mechanism to expand capacity would be to permit the farm mutual companies to compete on an equal footing with other insurance companies for non-agricultural business. This step has already been recommended by the Dupré Commission and has been under consideration by the government for some time. Provided that the farm mutuals are subject to the same regulatory and supervisory requirements to which all other companies are or will be subject, and provided that an acceptable compensation fund mechanism is also in place, there is no reason why the appropriate amendments to the Insurance Act and the relevant federal legislation should be delayed any longer.

The Task Force therefore recommends that:

- B.17 The proposals of the Ontario Mutual Assurance Association should be proceeded with as quickly as possible. These proposals will give farm mutuals the same investment powers as other insurers, and the ability to form subsidiaries designed to provide commercial and urban insurance coverages. Such subsidiaries should be subject to capital requirements, regulations and taxation comparable to those applying to joint stock property and casualty insurers. At the same time, the guarantee fund of the farm mutuals must be extended to their subsidiaries to ensure adequate protection of the public.
- B.18 Farm mutuals should also be required to conform to the same rules for financial reporting and disclosure as other insurers.

Extended Functions of Captive Insurers

Some use has been made by larger businesses in Canada of captive insurance companies. The primary purpose for most captive insurance companies is to provide a pool of funds from which to pay the insured's claims. The captive is also used as a focal point to establish a pool of risk in the hopes of being able to obtain reinsurance.

These arrangements for corporations and generally their affiliated companies permit the placing of insurance for corporate needs. Except for automobile insurance, which must be placed with licenced insurers, any person in Ontario is free to purchase insurance outside the province, for his own needs. The advantage to the insured is obvious, in that there is ability to structure a tailor-made insurance program and capacity can be assured. Premiums remain a deductible expense in doing business.

Special legislation exists in several American states and in a number of offshore countries, such as Bermuda. This special legislation recognizes that certain insureds do not need the regulatory protection offered to the general public. In most instances, the usual insurance-type investment clauses are not applicable. An additional attraction is that the income earned on investments by the captive insurer may not attract tax in the domicile of the parent owner.

In instances where captive insurers insure other third parties, it is customary to do so by a reinsurance arrangement with a fronting licenced insurer.

Captives may also be considered as an alternative in providing insurance to other than their owners or affiliates. Current provisions of the regulations made under the Registered Insurance Brokers' Act of Ontario allow brokers to place, under certain conditions, insurance with unlicenced insurers -- more particularly, when "sufficient insurance cannot be obtained at reasonable rates on a form of contract required by the member of the public from insurers licensed under the Insurance Act." The owners of such captives might well consider extending their sphere of operation to provide insurance coverages under these arrangements to other than their own persons.

The Task Force is of the view that increased use of the captive insurer mechanism would be an effective way of expanding capacity, particularly in the more intractable problem areas of the liability insurance sector. In particular, if professional and products liability insurance needs can be met under appropriate terms for particular corporations, then greater capacity will be available in the conventional insurance market for consumer coverages and less hazardous risks.

It would be preferable, however, to encourage captive insurers to remain onshore. This could be accomplished, for example, by permitting the deferral of income tax on retained earnings until such profits are distributed as dividends. Rules and limitations to avoid abuse would be required. Such a step would necessitate the legislative reversal of the recent decision in the Consolidated Bathurst case that held that premiums paid, for example, by a Canadian company to a controlled captive will not be deductible for tax purposes (although premiums paid by a Canadian company to a captive owned by a foreign parent may be deductible). In addition, at the moment, under the Income Tax Act a Canadian company is taxed on its share of a captive's underwriting and investment income (to the extent that it relates to Canadian risks), if the captive is considered a controlled foreign affiliate.

In light of the foregoing, the Task Force recommends that:

- B.19 The Government of Ontario should take steps to facilitate the formation of domestic captive insurance companies and the Insurance Act should be amended to extend to such captive insurers. The new provisions should permit sophisticated buyers of insurance to form their own insurance companies with a minimum of regulatory oversight.
- B.20 Revenue Canada should be requested to review its position vis à vis captive insurers, and the federal government should be urged to make any appropriate changes to the Income Tax Act if necessary.

Self-Insurance

Many corporations retain the responsibility for their risks by establishing self-funded reserves. In such instances, corporations endeavour to retain the portion of the risk compatible with their own risk-bearing capacity. In short, they settle their own claims out of their own funds. In most instances,

they provide for a form of excess insurance for losses sustained over a certain amount.

The Task Force believes that self-insurance is an increasingly appropriate longer-term response to capacity constraints, especially for large public bodies and for specialized lines of liability, provided that the amount of risk retained is within the limits of the risk capacity. In this connection, in a paper prepared for the Task Force, Marsha Chandler and Carolyn Tuohy set out the following useful assessment of the trend to self-insurance:

Informal provisions for self-insurance have the advantage for the insuree that they avoid insurance company loading factors; and, for low-risk insurees, they also avoid the need to share in the expected claims costs of higher-risk members of an insurance pool. From a social point of view, however, self-insurance, especially for liability losses, presents several problems. Most notably, it may fail to protect third parties, including consumers not sophisticated enough to demand "tied packages", that is, products or services backed by insurance. It may also raise problems of adverse selection in which lower risk entities self insure, and higher-risk entities remain in the insurance market, driving up premiums and driving even more entities at the lower end of the risk spectrum to self insure.

Although self-insurance by individuals or individual firms may not be desirable from a social perspective, it may nonetheless be appropriate for government to encourage the formation of self-insured groups. These groups could take a variety of forms. One variation has been noted above -- the suggestion that groups within the same risk class form pools for the purpose of taking on large deductibles, essentially treating conventional insurance as reinsurance. Such groups would function over time as more knowledgeable consumers in the insurance market, and as organized consumer counterweights to industry interest in the political arena (the increasing trend for large U.S. corporations to withdraw from the U.S. health insurance market in favour of self-insurance provides a somewhat analogous illustration of the gains in economic and political power to be made through self-insurance). (Etheredge, 1985.)

Another variation on group liability self-insurance mechanisms is presented by "protective associations" on the model of the Canadian Medical Protective Association, which are committed not only to pooling but also to reducing the risk of loss to their members. The CMPA decides which malpractice claims it will settle out of court, and which it will force to the courts; and provides legal services to its members as well as compensation for liability losses. It has been argued that the CMPA has reduced its members' losses by holding to a very restrictive definition of liability, and forcing any challenges to that definition to be litigated at potentially high cost to the plaintiff (rather than by monitoring the quality of its members' practices). It nonetheless demonstrates one model of self-insurance which, together with features of the Canadian tort liability system, has contributed to

markedly lower costs of medical malpractice insurance in Canada than in the U.S.

One particular area where the Task Force believes that self-insurance should be positively encouraged is in respect of large corporations and the retention of more responsibility for their own risks. To this end, tax changes must be made to allow corporations to take tax deductions on "self-funded" reserves in the same way that an insurance company can on its claims reserves. (At present, a "self-funded" organization can only take a tax deduction at the time a claim is actually paid.)¹

Three important benefits expected to accrue from greater self-funding are:

- (1) More insurance capacity would be freed up for those smaller business entities and/or individuals whose lower risk-bearing capacity render them more dependent on insurance.
- (2) More insurance capacity would be freed up for new types of cover needed to respond to our changing environment and for catastrophe cover.
- (3) Greater levels of risk retention would, at least in the long run, lead to greater attention to loss prevention and control, which will benefit both the individual corporations and society as a whole.

In addition, other long-term benefits for society would be realized. In the area of pollution liability, for instance, where insurance cover is difficult and sometimes impossible to obtain, it could clearly be beneficial to society if companies with a high pollution liability exposure were able -- or even required -- to set aside in a trust fund sums of money to cover the costs they will eventually have to pay for the damage they are causing to the environment. If this did nothing more than focus the attention of industrial companies on the "bottom-line" impact of environmentally damaging processes, it could be of considerable benefit.

¹ Note that the Senate Committee voted to approve an expansion of the Risk Retention Act, 1981 to allow the formation of groups for self-insuring any type of commercial liability, not simply product liability.

The Task Force therefore recommends that:

- B.21 The Government of Ontario should request the federal government to amend the Income Tax Act to permit corporations to take tax deductions on self-funded reserves in the same way that an insurance company can on its claim reserves.

Insurance Exchange

Another means of ensuring adequate capacity is to ensure the availability of adequate reinsurance. In general, it can be said that reinsurance fulfills two functions. It shifts risks from an insurer whose solvency might be jeopardized if it retained too much risk. And it shelters primary insurers against major losses and therefore tends to stabilize profits and losses of insurers, permit more orderly growth and protect capital for expansion.

There is a danger, however, in primary insurers becoming excessively reliant on reinsurance, particularly that provided by unregistered reinsurers, who rapidly disappeared at the onset of the crunch in 1986. This became all too clear with the five recent insolvencies of general insurers Ontario, all of which had failed to retain sufficient amounts of the risk. Clearly, limitations on the use of unregistered insurance and increased minimum retention ratios are desirable, and recommendations to this end have been set out in Part D.

The source of the recent reinsurance capacity crunch, which culminated in the expiry and non-renewal of reinsurance treaties on December 31, 1985, appears to be primarily related to the extreme unpredictability of court awards and settlements in the United States. Offshore reinsurers are simply convinced that the Canadian legal system does not differ substantially from that in the United States and are firmly of the view that the developments in professional and product liability, in particular, will inevitably find their way into Canada.

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The following report of a series of meetings with reinsurers at Lloyd's in April is illuminating:

One of our problems in Canada, particularly in Ontario, is that we just do not have a broad enough economic or capital base. For example, there are simply not enough risks of a certain homogeneous type to achieve a spread. The example of providing fidelity insurance coverage to Canadian banks was cited. Here, there are relatively few Canadian banks and yet they require a minimum of say \$25 million coverage of this nature. Such a coverage entails a premium of say \$2 million a year, if the coverage is limited to the few Canadian banks. A similar level of coverage in the United States of \$25 million a year would result in total premiums well in excess of \$25 million a year. Consequently, since the ratio of premium to coverage is so important, Canadian banks are lumped in with American, European and indeed Far Eastern banks. Thus, it is quite natural in insurance terms to join Canadian experience with that of its immediate neighbours, when considering specialty lines of insurance.

More importantly, Canadians export manufactured products into the United States and these products are subject to product liability. In addition, Canadian bus lines, trucking companies and other Canadian enterprises habitually trade into the United States. Furthermore, Canadian tourists visit the United States and Americans visit Canada. The fortunes of the two jurisdictions are too closely tied to effect a proper distinction from an insurance standpoint for liability coverage.

Individuals in the London insurance market recognize that Ontario has separate and distinct legal and judicial systems. They are also aware of our well-developed social welfare system. Underwriters at Lloyd's recognize this distinction, but it is overshadowed by the need to spread risk and the strong connection of Canada with the United States. Consequently, from an insurance standpoint, risks in Ontario are seldom distinguished by underwriters in the London market from those in the United States of America.

In light of the foregoing rather gloomy prognosis for the return of reinsurers to the North American market, the Task Force believes that steps establishment must be taken to accelerate the establishment of the proposed Canadian Insurance Exchange. It is the understanding of the Task Force that sufficient expressions of interest have now been received from potential

investors to create a usable exchange and that this capital is from other-than-traditional insurance sources.

While the Canadian Insurance Exchange, through its syndicates, will not be limited to reinsurance, the Task Force is of the opinion that a reinsurance facility for Canadian primary insurers within its operations would be a logical development and would have the benefit of made-in-Canada underwriting. In addition, the Exchange syndicates could write directly more difficult-to-place commercial risks.

As is the case with Lloyd's of London, the exchange will bring together insurance capital and the expertise of many underwriters and could go far to provide much-needed reinsurance capacity within Canada. In addition, as noted by Robert Hilborn, Chairman of the Insurance Exchange: "The new facility would create employment, enlarge the province's tax base, enhance Ontario's reputation as a financial centre of international significance and create a source of Canadian-controlled reinsurance to write specialized risks."

The Task Force therefore recommends that:

- B.22 The Government of Ontario should take immediate steps, with the support of its federal and provincial counterparts, to establish the Canadian Insurance Exchange in time to take advantage of the reinsurance treaty renewal period commencing January 1, 1987.

III THE CALL FOR TORT REFORM

Blaming the Courts: The American Spill-Over

In the more than two hundred briefs and position papers received by the Task Force, one message became very clear: a growing number of Canadians believe that high court awards are a primary cause of the current liability insurance crisis. This was a constant theme -- both from insurers and from insureds. The concern was voiced again and again that the court system, particularly in the personal injury area, has grown out of control: that there has been a explosion in the size of liability awards, largely imposed by compensation-driven judges searching for deep-pocket defendants. Indeed, in a recent Gallup Poll released on March 31, 1986, 33% of the persons polled believed that escalating court awards were largely to blame for the current insurance crisis.

These opinions were undoubtedly influenced by developments in the United States. Research conducted for the Task Force in this area reveals that in recent years the American tort system has undergone a "dramatic transformation".¹ There has been a virtual explosion in liability and liability litigation. Multi-million dollar jury awards are now commonplace, and American courts continue to expand traditional notions of negligence to new areas of activity and injury. The Trebilcock study found that in the United States, "the liability insurance crisis ... is not a contrivance of the insurance industry, but in large part reflects an explosion both in the parameters and quantum of liability in the U.S. court system".

In a study released by the United States Department of Justice in February, 1986, the Tort Policy Working Group concluded that American tort law was "a major cause of the insurance availability and affordability crisis". The Tort Policy Working Group found that extreme uncertainty had been created in the tort litigation/liability insurance system through rapidly changing standards of causation and liability. The study further found that "the rules of the game have become so unpredictable that the insurance industry often cannot assess liability risks with any degree of confidence." The consequence was further unpredictability and increasing controversy.

The growing consensus in the United States that the tort system is in large measure responsible for the crisis in liability insurance has prompted wide-ranging demands for the reform of the tort system. Today hundreds of bills for tort reform are making their way through the state legislatures, and both houses of Congress. Although they vary in substance and style, the basic message remains the same: legislative intervention is needed to rein in the American tort system.

The proposals for reform advanced by the Tort Policy Working Group are typical of the reform measures that are being proposed in the various state legislatures today. They include the following:

¹ See Appendix 2.

- placing legislative limits or "caps" on jury awards for such intangible or non-economic losses as "pain and suffering";
- placing similar "caps" on the award of punitive damages;
- abolishing the doctrine of joint and several liability except in those cases where the co-defendants have acted in concert;
- abolishing the recovery of collateral benefits;
- substantially regulating the contingent fee system.

In essence, these and other related proposals are concerned primarily with limiting or restricting the amount of damages that American juries can award for pain and suffering or for other equally intangible but more punitive objectives.

These much-publicized American developments have undoubtedly affected perceptions in Canada as well. Even though the Canadian tort system differs in several important respects, observers could not be faulted for thinking that similar difficulties were developing in Canada as well. After all, we are a major trading partner of the United States. Many of our products are exported to that market, and consequently many of our exporters are affected by developments in American tort law.

More importantly, however, the belief that court awards are escalating or that negligence liability is expanding is not without foundation. The recent and much-publicized award of \$6.3 million imposed on the City of Brampton for catastrophic injuries sustained by a young motorbike rider became, understandably, a rallying cry for American-style tort reform. In dozens of briefs, the Task Force was asked to consider placing legislative limits and restrictions upon the Ontario judiciary similar to those proposed in the United States. Many of these proposals however are rooted in a fundamental misunderstanding of Canadian tort law and the nature of the Ontario judicial system.

Ontario is not "California North": At Least Not Yet

It is important at the outset to clarify some of the misconceptions that pervade much of the public debate about the Canadian tort system and the extent to which it can be blamed for the current insurance crisis. Although the American judicial system shares the common law tradition, the Canadian tort system is different in several important respects. The major differences are these:

- Canadian tort cases are usually determined by a judge alone and not by juries. In the United States, the injured victim has a constitutionally guaranteed right to a jury trial, and multi-million dollar jury awards are commonplace.
- The award for pain and suffering, which remains a large component of the personal injury award in the United States, was judicially limited in 1978 in Canada to a \$100,000 maximum. Given inflation, this judicially imposed "cap" on pain and suffering is now approximately \$184,000.
- Punitive damages, which in the United States also constitute a significant component of the jury award in a serious injury case, are very rarely granted by Canadian courts.
- The contingent fee system in use in the United States, which arguably leads to both more speculative actions being brought and to the inflation of awards by juries that are sensitive to the net value of awards to plaintiffs, is not widely utilized anywhere in Canada and is prohibited in Ontario.
- A number of procedural devices, e.g., class actions that allow the aggregation of individual loss and play a significant role in American tort litigation, are not available in Ontario.

In sum, Ontario is not "California North". Our tort system is different. There is no need to restrain juries because juries are rarely used. There is no need to place legislative limits on pain and suffering awards because a \$100,000 ceiling was imposed judicially in 1978. There is no need to regulate contingent fees or reform class actions because these too do not exist.

And yet, having said this, the Task Force recognizes that in a fundamental way, even given the formal differences described above, there are deep similarities in the developing structure of American and Canadian tort law.

Although Ontario is decidedly not a California of the North today, there is every indication that it may become so in the foreseeable future -- not so much in the escalation of the size of awards but rather in the continuing expansion and extension of liability. This point is developed more fully below but perhaps a brief clarification is necessary.

The inevitable tendency to track American developments in this area will not mainly be a in terms of the size of the award. After all, the \$100,000 cap imposed by the "trilogy"¹ in 1978 will ensure that, for all intents and purposes, even catastrophic injury litigation will be focused primarily on actual economic losses and objectively ascertained compensation needs for future care etc. The much publicized Brampton decision has been a source of much confusion on this point. In McErlean v. City of Brampton, the \$6.3 million award to the young quadriplegic had two main components: approximately \$3 million to compensate for actual injury, lost income and future care, costs, etc. -- and another \$3 million as a necessary "gross-up" to deal with the tax consequences of investing the lump sum award over a number of years. There is nothing in the Brampton case or in the other multi-million dollar judgments that we have reviewed that would suggest that Ontario courts are awarding "too much money". The \$6.3 million award in the Brampton case has been fundamentally misunderstood both by the media and by many who are calling for tort reform. The real controversy in these cases, including Brampton, is not in the size of the award. Indeed, the Task Force learned that before the court gave judgment in this case, counsel had come to an agreement that if liability was found, an award of \$6.3 million was a reasonable one in the circumstances.

The importance of the Brampton decision and the seeds of continuing controversy lie, not in the size of the award, but rather in the imposition of liability. It is here that the Ontario tort system displays an unsettling but unavoidable parallel with the American. A crucial finding in the Trebilcock study was that the current "explosion" in American tort law was not the result of judicial extensions of already advanced American strict liability doctrines but rather the judicial extension of traditional negligence liability and its application to an ever-widening range of activities and injuries. The study found that:

¹ Referring to the decisions of the Supreme Court of Canada in Andrews v. Grand & Toy, Arnold v. Teno, and Thornton v. Prince George.

...the so-called "explosion" of tort liability in the U.S. in the past quarter century has been quite explicitly an explosion of negligence liability rather than a substantial extension of the spheres of application of strict liability. Many of the sectors that have recently identified problems of insurability in the U.S. are indubitably governed by negligence principles. These factors comprise all suppliers of services (physicians and other professionals, daycare centres, municipalities, ski operators, bus and truck operators, etc.). The extension of liability to psychiatrists who fail to warn third parties of patients' dangerous propensities, the failure of tavern or restaurant proprietors to prevent patrons leaving their premises too drunk to drive safely; the liability of proprietors of nursing homes or daycare centres for abuse of patients or children by staff members; the liability of municipalities for abuse of authority, excessive force or failure to act by police officers, or for recreational accidents occurring in the course of activities organized under their aegis; the liability of physicians for "bad babies"; the liabilities of accountants for improperly executed audits, all represent extensions of liability to particular acts or omissions through the application of traditional negligence principles.

There is every indication that similar tendencies exist in Canadian negligence law and that similar developments will occur in the future in Canada as well. The reason for this inevitable expansion of liability, even within the bounds of traditional negligence doctrine, is a matter that is intractably and unavoidably rooted in what we will later describe as the "insurance-deterrance dilemma" in modern tort law.

This point will be developed in more detail below. Suffice it to say here that the similarities between the Canadian and American tort systems will prove to be more significant than the formal differences that were described above. The differences in the future will be differences in degree not differences in kind.

A number of briefs received by the Task Force anticipated these concerns and presented a series of specific proposals for the reform of the tort system.

Proposals to Reform the Tort System

The Task Force is particularly obliged to the Canadian Bar Association of Ontario (CBAO) for its thoughtful presentation. The reforms suggested by the

CBAO were also voiced by a number of other groups and associations, which had also identified other similar areas of concern. All of these reforms were proposed in good faith as measures that would help minimize or eliminate the waste, delay and inefficiency of the present tort system and make the tort-liability insurance system more predictable and less costly. The Task Force has organized the main proposals without further attribution under the following eight categories:

(1) Family Law Act Reforms

The concern here is that recent family law reform measures have allowed the relatives of an accident-victim to recover damages for loss of "care, guidance and companionship" in addition to pecuniary losses, not only in fatal accident cases, but also now in cases involving bodily injury. This provision, now section 61(2)(e) of the Family Law Act, 1986, is said to have resulted in a flood of numerous and often trivial claims by distant dependents. The proposal here is to amend this provision to limit recovery to those cases where the loss of guidance, care and companionship was shown to be "serious or permanent".

(2) Pre-judgment Interest

The concern here is that the present pre-judgment interest rules in the Courts of Justice Act have created particular problems in the personal injury area -- that more plaintiffs are now delaying the expeditious resolution of their claim in order to increase the pre-judgment interest award and that this in turn was exacerbating insurers' difficulty in predicting reserves and overall premium pricing. To deal with these concerns, the reform suggested is an amendment to the rules that would provide that pre-judgment interest for non-economic losses in personal injury cases would not begin to run until sufficient medical information had been provided to the defendant or until the plaintiff had made himself available for medical examination.

(3) Gross-up and Structured Judgments

As noted earlier, a large part of the lump sum personal injury judgment reflects a tax "gross-up" component. The need for such a tax gross-up arises because, in certain cases of serious injury requiring long-term care, the normal award has to be increased to meet the tax obligations that will arise when the lump sum is invested. The gross-up problem does not arise, of course, where the parties agree to a "structured settlement" in lieu of a lump sum payment. Structured settlements are permitted under the Courts of Justice Act provided they are entered into with the consent of all parties. Injured plaintiffs who opt for the lump sum award (with the tax "gross-up" feature) can still do so.

The proposal which was most frequently advanced is that the Courts of Justice Act be amended to give courts the discretionary power to impose a "structured judgment" in lieu of the lump sum, even upon an unwilling plaintiff when the court considers it to be in his or her best interest. In this way, the difficulties and uncertainties associated with "gross-up" would be avoided, judgments in serious personal injury cases would become smaller and liability insurance premiums would become more affordable.

(4) Collateral Benefits and "Double Recovery"

The concern here is in the waste and duplication that arguably arises when courts allow injured victims the right to retain benefits received from collateral sources, e.g., private disability insurance, public assistance schemes, etc. By failing to include the collateral benefits in the calculation of the "actual" loss, courts are said to allow a "double recovery" on some of the items. The main proposal is for legislative intervention to reverse recent judicial decisions that have held that collateral benefits are irrelevant in calculating the amount the tortfeasor should be asked to pay. Other proposals would permit the retention of some benefits received from collateral sources, but not others.

(5) Joint and Several Liability

Under the provisions of the Negligence Act, joint tortfeasors are jointly and severally liable to the plaintiff for his injuries and thus equally responsible for the total award regardless of the respective degrees of fault or responsibility for the actual injury. The problem materializes when one or more of the joint tortfeasors turn out to be impecunious. The solvent co-defendant, who may have been only 1% to blame, will have to pay 100% of the judgment.

The proposal here is to abolish the joint and several liability doctrine so that joint tortfeasors will be liable only in proportion to their degree of responsibility. The issue, of course, is who should bear the risk of a potentially impecunious defendant --the injured victim or a joint tortfeasor. Today the Negligence Act places the risk of an impecunious defendant on all of the joint tortfeasors. The reform being proposed would mean that plaintiffs entitled to a damage award would have to bear entirely the risks of non-recovery.

The Task Force recognizes that this is a matter of some complexity. The Task Force also notes that the problem of joint and several liability is exacerbated in the context of professional liability. As the Lilly study shows, the imposition of concurrent liability and its juxtaposition with joint and several liability have caused serious problems for building professionals and has accentuated the need for a careful and systematic study of both of these doctrines. The Lilly Study is attached in Appendix 10.

(6) Limitations

The current Limitations Act is an amalgam of statutory provisions from thirteen English statutes, some dating back to 1588. By any measure the current legislation is seriously out of date and in need of reform. Much of it is unintelligible to the layperson and unsuited to the needs of modern litigation. Fortunately, the

Ministry of the Attorney General is presently reviewing Bill 160, An Act to Revise the Limitations Act. Bill 160 received first reading on December 16, 1983, but then died on the Order Paper. The Policy Development Division of the Ministry of the Attorney General is currently soliciting views from industry groups and organizations to see whether and to what extent Bill 160 should be modified and improved.

The concerns expressed to the Task Force relate mainly to the problem of long-tail liability. The problems are particularly acute for architects, engineers and health-care professionals.

Because the existing limitation periods (six years for tort and one year for medical injuries) run from the date of "discovery", this means liability can be imposed and damages awarded years after the actual service was performed, and in some cases even after the supplier of the service has retired and his or her "claims-made" coverage has lapsed.

The reforms proposed here are reforms to add certainty and "cut-off" to long-tail claims. The Lilly study urges that limitation legislation be amended so that the limitation period for all professionals would run from the date of the last professional service.

(7) Good Samaritan Legislation

A number of groups and organizations, particularly those in the voluntary sector, have urged that "Good Samaritan Legislation" be enacted to provide greater tort protection to volunteers providing medical assistance in good faith. Good Samaritan legislation is now in effect in Alberta and Nova Scotia. In these provinces Good Samaritans are immune from suit unless "gross negligence" can be shown. The Task Force also received proposals for application of the Good Samaritan approach beyond the realm of medical assistance.

This matter was studied by the Ontario Law Reform Commission (OLRC) in 1970. The OLRC rejected the need for a Good Samaritan statute, noting that at that time the case for such legislative intervention had not been established. In their brief to the Task Force, the Ministry of the Attorney General notes that in the intervening years there have been no reported cases where Good Samaritans or other volunteers were held liable for assisting in a medical emergency. The brief asks why such legislation is now thought to be necessary.

Notwithstanding the findings of the OLRC, the Task Force understands that the problems of insurance availability and affordability have been particularly acute in the voluntary sector. Indeed, Michigan and a number of other states are currently considering Good Samaritan legislation as a partial response to the insurance crisis.

(7) Arbitration

Finally, one of the briefs received suggested that arbitration of automobile accident benefits under the Standard Automobile Policy be instituted, at least on a trial basis, to facilitate a more expeditious resolution of the smaller automobile accident claims.

Those were the main categories of suggested reform. They were not the only reforms suggested. Scattered through the dozens of other briefs and submissions were reform proposals relating to corporate law (incorporation of professionals and hospitals corporate liability), civil procedure (the demand for a more generalized security for costs rule to minimize frivolous lawsuits) and tax reform (amendments to federal tax laws to accelerate reserve build-up for professional self-insurance plans).

The Chairman's Comments on Proposals to Reform the Tort System

The Chairman of the Task Force is not a lawyer nor a scholar of the law. His own comments on proposals to reform the tort system are offered with more than a touch of humility and tentativeness. But they must be offered, for whatever help they may be to public debate and action. In the end, it is the citizens, not the lawyers, who must decide and support tort reforms or choose other courses.

In the broadest sense, the choices are among an evolutionary, incremental, piecemeal approach to reform; a more fundamental, integrated, planned approach to reform; and some blend of the two. No one is satisfied with the status quo. Virtually everybody the Task Force encountered argued for change. The question is what changes and how. The Chairman believes that the main emphasis in the reform should be put on a fundamental, integrated, planned approach for reasons to be developed in the rest of this part of the report. But more evolutionary, incremental, piecemeal approaches also deserve careful consideration.

In recent decades, partly as a result of legislation and regulation, but mainly through the tort-litigation system centring on the courts, change has been wrought in a gradualist, decentralized process that has attempted to reconcile the rights and responsibilities of individuals with those of society. In the work of the Task Force, the Chairman has come to respect what has been accomplished in this way in Canada and in Ontario. The concepts of tort have been interpreted and applied more widely to meet society's needs for compensation for bodily injury. The standards of compensation have been related to the changing needs and capabilities of Canadians. The standards have reflected changes in society's choices regarding home versus institutional care, and life-cycle income expectations in the country. These standards have been applied to individual cases, having regard for individual circumstances. Limits have been placed by the Supreme Court of Canada on awards for pain and suffering, limits which appear to have widespread acceptability in Canada. The outcome of the process is far from perfect, but it could have been much worse. Any other process that is used in whole or part to deal with compensation and deterrence in relation to accidents will have to deal with the same issues as the tort-litigation system has dealt with.

The proposals for tort reform are mainly modest legislative or administrative changes that would help shape the framework or practices of the tort-litigation system. They were offered as contributions to the evolutionary, incremental, piecemeal approach to reform. The Canadian Bar Association of Ontario deserves commendation for its major effort to build a broad consensus around a set of modest proposals for tort reform; it is to be hoped that that process will continue. The subjects for reform were not held out to be causes of the insurance crisis, nor the reforms as cures. Rather, at a time when the insurance crunch created the possibility of building some consensus for reform, an effort at finding useful compromises on a number of issues was made among a wide range of interests, not just insurers.

As to the substance of some of the proposals for tort reform, the Chairman offers the following comments. Regarding pre-judgment interest, it is important to note that no change is proposed in the entitlement to pre-judgment interest for economic losses; this is as it should be. Regarding gross-up and structured settlements, as will be argued later in the Report, if structured settlements to meet the cost of care are not taxable (a proper position), then neither should the equivalent lump sums to meet the cost of care be taxable. The case for more use of structured settlements is a strong one, quite apart from the issue of taxation. Consideration should be given to allowing settlements to be made by way of a contract which would deliver a program of benefits, instead of the usual detailed structure based on assumed contingency and economic projections.. Regarding collateral benefits, the Chairman is inclined to disallow the right to retain benefits from public programs, at least for the improved program of auto accident benefits proposed later in this report. To deny collateral benefits arising from private arrangements does seem improper. No additional comments are offered on the Family Law Act, the joint and several liability doctrine, or limitation periods.

Is Tort Reform the Answer?

Can the basic problems that confront the tort-insurance system and that in large part have caused the liability insurance "crisis" be resolved through tort reform? The Task Force has given this difficult question careful thought;

indeed, it could not have done otherwise. As has already been acknowledged, in the area of personal injury compensation the tort system has played an ongoing and conscientious role. The Canadian courts have demonstrated a remarkable ability to respond institutionally when a response was required. For example, an important reason why Ontario has not become a "California North" was the sound judicial decision in 1978 to place a \$100,000 cap on pain and suffering and thus to confine rigorously the otherwise arbitrary process of measuring intangible loss. The Task Force recognizes that in many areas the Canadian tort system has shown that it can be counted on to respond to the changing needs of Canadian society in sensible ways. In the last two decades the tort system -- both the judges and the personal injury bar -- have accomplished a great deal and have much to be proud of.

The Task Force has concluded, however, that the problems that pervade the personal injury area and that in large measure have caused the current liability insurance "crisis" cannot be resolved through further reform of the tort system.

The basic problem confronting the Task Force in the liability insurance area is threefold: availability, affordability and overall adequacy. The various proposals for reform discussed above and even the more dramatic measures suggested in the United States could conceivably improve matters, but not enough. Tort reform is not the answer for three basic reasons.

First and foremost, no strong connection has been established between any of the eight or more areas of difficulty or all eight together and the present insurance crisis in Ontario. No evidence has been adduced to demonstrate that any of these areas of difficulty are relatable to the present problems of the availability or affordability of insurance. In fairness to many of the groups that voiced these concerns, the point was made to the Task Force that such evidence would be difficult if not impossible to obtain. Nonetheless, even with the contributions of many experienced individuals, the Task Force was unable to determine the size or significance of the these various difficulties or their relevance to the current insurance crisis. Indeed, many of the proposals were offered as changes that would make only modest differences to the cost and availability of insurance.

Secondly, even if some or all of these measures were implemented, there is no reason to believe that the tort system would in fact be much "improved" or that the liability insurance system would be stabilized. The evidence thus far suggests that the sensible direction for reform is not in adding ad hoc restrictions to the tort system but rather in the analysis of its basic rationale.

This brings us to the third and most important point. Any reform of the tort system should only be implemented when the objectives of that system have been satisfactorily identified. The growing contradiction between the deterrence objective and the compensation objective, particularly given the phenomenon of modern insurance, will be discussed in more detail below. Here, two questions will be asked. If deterrence is indeed the objective, and this objective requires that tortfeasors be exposed to all of the social costs of their negligent conduct and pay full compensation for injury, why is it justifiable to restrict or limit compensation awards as some of the reform proposals would do? On the other hand, if compensation is the objective, then why should recovery be limited or restricted in the ways suggested? As the Trebilcock study demonstrates, many of the tort reform proposals that are currently being considered both in the United States and in Canada are rendered incoherent when subjected to careful analysis.

Much of the problem, of course, is that the analysis is itself confused and contradictory. This in large measure is the result of what we later describe as "the insurance-deterrence dilemma". But whatever it is, it is certainly clear that when the operation and objectives of the tort system are mired in contradiction and confusion, adding ad hoc "reform" measures that exacerbate the problem is no solution.

Some Interim Measures

The Task Force offers a more fundamental approach to tort reform in Part IV below. It recognizes, however, that some time may elapse before these measures can be implemented.

Several of the proposals for tort reform set out above are sensible in themselves, even if they would not make big differences to the overall efficiency and equity of the tort system or the fundamental capacity of the property and casualty insurance industry to meet the needs of insureds. They would probably do some good, and it appears to the Task Force little harm. They need not prevent the more fundamental approaches to tort reform. Therefore, the Task Force recommends that:

- B.23 The Government of Ontario should consider taking action to introduce changes in the spirit of the proposals reported above on pre-judgement interest, gross-up and structured settlements, and joint and several liability and limitations. The Government should consider the treatment of collateral benefits in connection with recommendations C.1 and C.2 below for reform of the compensation for bodily injury due to auto accidents. The Government should give prompt consideration to the risk and liability problems of volunteers. The industry and the Government should seek to develop and apply arbitration as an alternative method of dispute resolution in accident compensation cases.

One of the most frustrating problems for the Task Force arose from the scarcity of systematic evidence on awards and settlements and on elements in the legislation and the tort-litigation system that contributed to the determination of awards and settlements. The Task Force attempted to develop additional evidence, but had neither the time nor the resources for a successful effort. The Task Force is convinced that it is possible and economical, particularly if sampling methods are used, to gather future evidence on awards and settlements and on the factors determining their nature and size. Accordingly, the Task Force recommends that:

- B.24 The Government of Ontario should develop and implement, with the co-operation of the industry, a statistical plan for the gathering of data and the analysis of awards and settlements of compensation for accidents, including the components that are used in building up overall awards or settlements.

It is desirable that the analysis of awards and settlements be reviewed periodically by a committee of the Legislature, perhaps at the time of the review of the annual report of the Superintendent of Insurance.

The tort reforms described above should be studied further. Any that are implemented soon should be tracked, and all of them deserve more careful study than has taken place to date. The studies should first determine whether these reforms have improved, or would in fact improve, the performance and predictability of the tort-liability insurance system, and second, determine which of these reforms would help meet the primary objectives of the modern tort system.

The Task Force notes that many of the items discussed above are already the subject of a major study that has just been commenced by the Ontario Law Reform Commission. The OLRC Project on Personal Injury Compensation provides an ideal opportunity for the further examination of these tort reform proposals. To this end, the Task Force will ensure that all the briefs and submissions received on these points and discussed briefly herein will be forwarded to Professor Stephen Waddams, the director of the Project on Personal Injury Compensation for his immediate attention.

The Task Force also recommends that:

- B.25 The OLRC study should expand its mandate to include each of the eight reform areas that were discussed above. In particular, the question of joint and several liability, appropriate limitation periods, the need for Good Samaritan legislation, and the arbitration of accident benefits, should be added to the OLRC personal injury study.
- B.26 A parallel study should be commenced by the OLRC to address problems that go beyond the personal injury area and that relate to liability under the tort system in general, particularly in the professional liability sphere. The Task Force will ensure that the OLRC obtains a copy of the Lilly study and related briefs and papers so that such questions as concurrent liability, joint and several liability, appropriate limitation periods, incorporation by professionals and other matters raised therein can be studied in a careful and systematic way.
- B.27 The work of the Ontario Law Reform Commission in both of these areas should be accelerated so that its final report can be made available as soon as possible.

IV THE NEED FOR A FUNDAMENTALLY DIFFERENT APPROACH TO ACCIDENT COMPENSATION

The Tort System in Context

Many people believe that the tort system plays a central role in injury reparation. The tort system is but one part of a multi-faceted compensation system. Most injuries are dealt with outside the court system, on a no-tort basis. In a study completed for the Task Force, Osborne describes the existing array of federal and provincial no-tort compensation programs.

The most obvious example, of course, is the Workers' Compensation Plan, which has been providing no-tort injury compensation since its enactment in 1914. Another is the Ontario Health Insurance Plan. A third is the range of no-fault benefits that have been "added on" to bolster automobile insurance coverage. Other examples are found in the disability benefits found under the unemployment insurance, Canada Pension Plan and veterans' allowance programs, provincial injury compensation schemes for victims of crime, and injury benefits that are available to many Canadians under private disability insurance plans.

For most Canadians compensation for personal injury is handled without the use of judges, lawyers or courts. Compensation is paid directly to the injured first party on a no-tort basis. The social and economic significance of these first party no-tort injury compensation schemes is substantial: over \$5 billion is paid out annually under these programs to accident victims in Canada. The proportional importance of tort within this larger context is relatively small: of the \$2.5 billion that was paid out under various Ontario accident compensation schemes in 1981 to injury victims, only \$250 million was paid through tort.¹ No-tort injury compensation, or what is popularly but somewhat inaccurately referred to as "no-fault" compensation, is not a novel notion in the overall Canadian context. Indeed, for most injuries, it is the norm.

Nonetheless, it is fair to say that the tort litigation fragment continues to assume a pre-eminent role in the compensation delivery system. It continues to attract attention not because it is central but because it is inherently uncertain.

¹ See paper prepared for the Task Force by Philip Osborne and research cited therein.

The Incoherence of Modern Tort Law: The Insurance-Deterrence Dilemma

Modern tort law, both in the United States and in Canada, has in recent years undergone a major transformation. In the personal injury area it has been dramatically transformed from a mechanism primarily concerned with deterrence to one whose main purpose is compensation. The Osborne study described this transformation as follows:

Since the turn of the century the tort of negligence has expanded from a relatively narrow and circumscribed field of civil liability to a generalized remedy for virtually all victims of negligent conduct. The duty of care now extends to almost all persons involved in activities which involve a risk to life and limb. This expansion of the scope of the tort negligence has been accompanied by a steady reformulation of the rules of liability to withstand the scope of compensation and to minimize the difficulties of the plaintiff in proving his or her case. The development has been typically judicial -- cautious, incremental and broadly within the boundaries of the fault concept. Nevertheless, the sum of the individual changes is a massive transformation of the fault system.

Both in the United States and in Canada tort law has seen the judicial expansion of negligence liability to include new areas of activity and injury. In a study completed for the Task Force, Trebilcock describes the Canadian and American developments in some detail. It is sufficient to note here that, notwithstanding the formal distinctions described earlier, fundamentally the differences between the American and Canadian tort systems are differences of degree not differences in kind. The American and Canadian judiciaries have both learned to manipulate highly malleable negligence doctrines in order to respond to the changing needs of modern society. Both judiciaries have learned to use tort for loss distribution.

Why has this transformation taken place? Here lies the irony. The basic reason for the dramatic transformation from deterrence to compensation is the phenomenon of modern liability insurance.

The massive transformation of the fault system ... is a change which is explicable only on the basis of liability insurance and judicial compassion for the victims of social progress. Judges who in their written judgements give no indication of the prevalence of liability insurance are in fact keenly aware that in almost all cases the defendant is not paying, and that they are in the last analysis deciding whether or not the plaintiff should be compensated from insurance monies... The prevalence of liability insurance fundamentally altered

the moralistic nature of the loss shifting function of fault. The loss shifting mechanism was converted into a loss spreading mechanism and it became more realistic to speak of the fault system as a fault-insurance system. The punitive and deterrent aspects of fault were diminished and compensation became the predominant function of tort law.¹

We discuss in more detail below the reasons why insurance was bound to undermine deterrence. These findings have now been documented in the literature to which we will turn to shortly. But the judiciary, in both the U.S. and Canada, seem to have recognized intuitively the implications of insurance.

Because of insurance, the analytical sequence in the judicial determination of "fault" has been reversed; rather than proceeding from a finding of liability to an award of compensation, the pervasiveness of insurance now has moved courts inevitably to look first to insurance and then to liability. The Trebilcock study found that "many judges even within a negligence regime are influenced by this revised sequence of insurance to liability in making determinations of negligence." Thus tort was effectively transformed into a system of social insurance for a wide range of societal risks, and it is the ultimate irony of the present insurance crisis that it was in the very success of modern liability insurance that the seeds were planted for the inevitable failure of tort.

With liability insurance, and a progressive and conscientious judiciary, the insurance-deterrence conundrum is made complete. The courts know they cannot deter; they also know they cannot fully and completely compensate all victims for all accidental injury. Thus, a "radical indeterminacy" is inevitably introduced into tort and, hence, an inherent instability.

In more human terms, the contradictory demands of the insurance-transformed tort system places an enormous strain upon the integrity of its judges. In a recent speech, Mr. Justice Krever of the Ontario Court of Appeal openly reflected on the incoherence of modern tort law and the inevitable pressures that sometimes lead judges into "intellectual dishonesty".¹ Mr. Justice Krever noted that judges will tend to find "fault" where none exists, so that totally innocent plaintiffs who suffer catastrophic injury can be adequately compensated by the wealthier insurers of equally blameless defendants.

¹ Osborne Study.

² Ontario Lawyers Weekly (February 21, 1986).

Mr. Justice Krever expressed a view that is undoubtedly shared by many of his colleagues:

It is not satisfactory to continue to base compensation only on the necessity to find fault because there is a propensity in those cases where there will be no real compensation, unless there is fault, towards intellectual dishonesty.

This is bad enough. But further tension is created when compensation has to be denied a seriously injured plaintiff simply because the elastic doctrines of modern negligence law have run out of elasticity and "fault" cannot be found. This happened in a recent case in which Mr. Justice Krever himself had sat as the trial judge.¹ A 58-year-old milkman was rendered a quadriplegic as a result of a non-negligently administered angiogram. He could not afford to hire help to turn him over two or three times at night as his medical condition required, and thus his 70-year-old wife had to do it herself. He could not afford to build ramps, or change the doorways where he lived, even to permit his wheelchair to be wheeled into the bathroom. The court found that "for all practical purposes, he became a virtual prisoner in the apartment". Nonetheless, despite the serious injury and the difficult consequences, Mr. Justice Krever had to deny compensation; "fault" could not be found and thus compensation could not be awarded. Mr. Justice Krever reflected on his decision:

Here's a person who through no fault of his own, entrusting himself to the health care system, became incapable of supporting himself and his wife and living an ordinary life, incapable of relieving his wife of the obligation of getting up in the night to turn him over. All of these things could have been made available by an award of damages, but you have to find fault.

He referred to his dilemma in the course of his reasons for judgment:

I confess to a feeling of discomfort over this state of affairs. In an enlightened and compassionate society, in which a patient who undergoes a necessary procedure who cannot afford to bear the entire loss through no fault of his own, and reposing full confidence in our system of medical care, suffers catastrophic disability but is not entitled to be compensated because of the absence of fault on the part of those involved in his care. While it may be that there is no remedy for this unfortunate and brave plaintiff and that this shortcoming cannot be corrected, there is in my view an urgent need for correction.

¹ Ferguson v. Hamilton Civic Hospital et. al. (1983) 40 O.R.2d.577.

The decision was appealed to the Ontario Court of Appeal, but the Court again had no alternative but to deny compensation. The Court of Appeal then said this:

We would not want to leave this case without adding that we are in complete sympathy and agreement with the learned trial judge's reasons ... we agree that in a situation such as the instant one, "an enlightened and compassionate society", to use the words of the learned trial judge, should do more.¹

In many ways the modern tort system, at least in the personal injury area, has reached the limits of its capacity. It cannot continue to operate as a compensation mechanism using notions of negligence or fault. This will only deepen the incoherence, instability and continuing unpredictability.

Any proposals for tort reform that continue to obscure the fundamental tension between insurance and deterrence should be rigorously resisted. The answer is not in adding illogic to incoherence, but in understanding that the tort system should not be asked to do the impossible. It cannot promote socially optimal insurance and deterrence objectives simultaneously. This is the present dilemma. There is no good reason to dig the courts into a deeper hole.

The Need For Reform

The answer lies in separating the compensation function from the deterrence function. The appropriate direction for reform would be in the design of a compensation system that works and also a deterrence system that works. Compensation should be principled and prompt. Deterrence should be principled and precise.

Although we have already suggested that in the personal injury area, the modern tort system cannot be counted on to perform these separate functions simultaneously, what if measures were taken to separate the compensation function from the deterrence function and then allow the tort system to continue doing one or the other. Could it succeed in either area?

This matter has been explored extensively both theoretically and empirically. The literature is voluminous. Suffice it here to draw the reader's

¹ Ferguson v. Hamilton Civil Hospital et. al., (1985) 50 O.R. 2d. 754 at 755 (Ont. C.A.)

attention to the most salient conclusions on these points. First, the deterrence function.

The Tort System and Deterrence

The inability of the tort-insurance system to achieve a significant deterrence objective has been documented in the literature. In 1979, the Ontario Law Reform Commission concluded that "tort law is a haphazard and inefficient means of deterrence." In 1984, the New South Wales Law Reform Commission went even further: "It is difficult to find any empirical evidence which proves that ... fault operates as an effective deterrent." A recent Canadian study summarized the reasons why the existing tort-insurance system cannot be expected to perform a deterrence role:

The root assumption and one that puts into serious question the overall utility of tort law ability deterrence theory, is that our system of common law adjudication is efficient. This threshold assumption of the efficiency of our courts and their determination and imposition of liability is crucial. The precision and sensitivity (the "efficiency") required for market deterrence to be a workable concept in practice is extraordinary. What you need is nothing less than a responsive, sophisticated, perfectly informed and litigationally motivated plaintiff; a fully informed judiciary with a confident capability in differential calculus; a litigation process that precludes below-social-cost settlement practices and ensures the accurate and immediate imposition of liability upon the appropriate supplier; a suppliers' marketplace that in fact does internalize the full brunt of the liability judgment and then reflects this internalization in subsequent product-pricing decisions; and, at the very least, a sophisticated insurance industry that is technologically able to resuscitate the deterrent effect of an insurance-covered tort judgment by means of a carefully calibrated and supplier-individualized rate-making procedure.

In sum, market deterrence to be at all workable requires a high degree of product information, victim initiative, judicial care and capability, supplier responsiveness, and insurance industry precision.¹

The same study went on to explain this analysis and reiterate the many findings world-wide as to why it is that the tort-insurance system cannot and does not achieve a significant deterrent objective. The reasons include the following:

¹ Belobaba, Products Liability and Personal Injury Compensation in Canada: Towards Integration and Rationalization (1983).

- o most injured people do not sue -- even when there is a reasonable basis for believing that the "fault" of another could be established;
- o for the small percentage of injury claims that actually proceed to litigation the parties are soon confronted with the highly elastic doctrinal norms of modern negligence law and with the realization that "fault" is not a self-defining concept, adding further imprecision and unpredictability to the process;
- o years may pass as the lawsuit winds its way through court with further delays that further dilute deterrence;
- o when judgment is finally delivered and damages are awarded there is no relationship between the severity of the sanction (the damage award) and the degree of "fault";
- o the judgment that is finally handed down by a well-intentioned court is rarely paid by the individual wrong-doer: in 9 cases out of 10 insurance fully absorbs the impact of the judicial decision;
- o any residual impact that might notionally remain is at most by way of an adjustment or increase in the insurance premium, years later, and as a study of the New York Insurance Department concluded in its report on automobile insurance, "individual last moment driver mistakes -- undeterred by fear of death, injury, imprisonment, fine or loss of license -- surely cannot be deterred by fear of civil liability against which one is insured", or one could add, by fear of a belated and imprecise adjustment in one's insurance premium.

Finally, even if these inefficiencies and obstacles could be cleared by a Herculian reform of the tort system, the question of deterrence, given the reality of modern insurance, is one that can be answered outside of tort. To the extent that modern insurance coverage means that in most situations deterrence will be achieved or will be achievable through the vehicle of premium variability or "experience rating", this very mechanism exists and can be worked into any first party no-tort accident compensation plan. That is, deterrence via higher

premium pricing or "penalty rating" is a common feature of many existing first party no-tort schemes and could easily be incorporated and developed as a component of the no-tort scheme that we set out in more detail below.

In sum, the best evidence we have today suggests that deterrence alone cannot justify the retention of the tort litigation fragment for non-work injuries. The theoretical foundations for the tort-market deterrence model are shaky, the practical problems as described above are insurmountable and, given the pervasiveness of modern liability insurance, and the need for deterrence through premium variability the tort-deterrence debate is ultimately irrelevant.

The Tort System and Compensation

If deterrence must be discarded as a rationale for preserving tort, the only other rationale that remains and one that ironically continues to drive the tort system today, in the personal injury area at least, is compensation. Here, the modern theoretical and empirical literature in its evaluation of tort as a compensation mechanism is even more compelling. The compensation rationale, put simply, fails both in theory and in practice.

The fundamental flaw in using tort to compensate through efficient insurance principles was explained in the Trebilcock study. The study correctly observed that efficient insurance cannot be delivered by the tort system because the system yields no coherent theory of how to identify the most efficient insurer. Given this incoherence and the uncertainties attendant on it, it would be futile to attempt to reform the tort system with insurance objectives or compensation objectives as the operative criteria.

The practical difficulties of continuing to utilize tort primarily as a compensation mechanism in the personal injury area have been documented extensively. The Osborne study discusses the findings in detail and the reader is referred to it for further amplification.¹ But here a brief summary may be useful. The basic reasons why the tort-insurance system remains an ineffective and inadequate compensation mechanism are:

¹Further support and documentation for these findings are provided in the Belobaba study.

- (1) Under tort, compensation is paid on an irrational basis. Even given the highly elastic and inevitably expanding "fault" liability doctrines, the seriously injured plaintiffs would still slip through the judicial net. For example, the 58-year-old milkman that was rendered a quadriplegic through the non-negligently administered angiogram discussed earlier should have been compensated. All of the judges hearing the case agreed that he should have been compensated, yet compensation was denied because "fault" could not be found. But if the compensation mechanism is intended to compensate for accidental injury, it should compensate for all accidental injury, whether slipping on a sidewalk, being hit by a car, or stupidly but tragically walking through a glass door.
- (2) Under tort, more than half of all modern injuries go uncompensated. The best evidence that we have today indicates that only 1/3 to 1/2 of accident victims get any compensation through the tort system. Others, including those that are seriously or catastrophically injured, are left behind or slip through the cracks.
- (3) Under tort, there is enormous delay. The tort system as it presently operates does not pay compensation promptly even to the winners. Evidence shows that it is not unusual for some cases to drag through the court system from 2 to 13 years. In the much-discussed Brampton decision, if liability is upheld on appeal, a further 3 or 4 years will go by before substantial compensation is actually paid -- in total some 13 years after the accident occurred. And these are the "winners" in the system.

In a recent study, Feldthusen and McNair examined how the Canadian tort system treats the "winners".¹ They studied one of the trilogy decisions of 1978, Teno vs. Arnold, where the Supreme Court of Canada awarded \$540,000 in damages to the parents of a severely disabled girl for injuries she sustained when hit by an ice cream truck that was driving through the neighbourhood. The case wound its way through the courts for nine years. Finally, the Supreme Court of Canada awarded the parents \$540,000. Did the Tenos "win"? The Feldthusen and McNair study provides a troubling answer:

¹ Feldthusen and McNair, "General Damages in Personal Injury Suits: The Supreme Court Trilogy", (1979), 28 U. of Toronto, L.J. 381.

The strength of the tort system which seemed to lie in how well it treats its "winners" -- they are persons who not only secure a judgment in their favour, but whose lump sum award by pure chance proves adequate to meet their lifetime needs. But ask whether Mrs. Teno, with her daughter's best interests at heart, would not rationally have preferred assured future care expenses and basic income for life, payable more or less routinely without a trial in 1969, through almost 9 years of uncertainty and expense, culminating finally in 1978. Would not many successful plaintiffs trade the "justice" and "satisfaction" of litigation and the non-pecuniary damages, for the relatively low-cost, fast and secure benefits that would be available, under a no-tort compensation scheme? If this is true of the "winner" of one of the largest Canadian awards ever, what of the "losers" -- the unsuccessful plaintiffs, the victims of non-tortious accidents, and the tortfeasors themselves?

- (4) The present tort-insurance system, although run by a well-intentioned and compassionate judiciary, remains riddled with uncertainty and unpredictability -- so much so that many commentators have described tort litigation as a "lottery". In the leading study of this question, O'Connell summarized the various factors that combine to make tort litigation very much like a game of chance:

The operation of the tort system is akin to a lottery. The most crucial criteria of payment are largely controlled by chance:

- a) Whether one is "lucky" enough to be injured by someone whose conduct or product can be proved faulty;
 - b) Whether that party's insurance limits or assets are sufficient to promise an award or settlement commensurate with losses and expenses;
 - c) Whether one's own innocence of faulty conduct can be proved; and
 - d) Whether one has the good fortune to retain a lawyer who can exploit all the variables before an impressionable judge or jury, including graphically portraying whatever pain one has suffered.¹
- (5) Even if all of the other deficiencies described above could be eliminated, the final one is the most serious: the inordinate financial cost of continuing to use tort for injury compensation. A large portion of every premium dollar is eaten up by the transaction costs of the tort-insurance system. More than 50 cents of every premium dollar is absorbed in the administrative and legal costs of running the system.

¹ O'Connell, The Lawsuit Lottery: Only the Lawyers Win (1979).

than 50 cents of the premium dollar is actually paid out in compensation under tort, compared with 80 to 90 cents that are paid out under no-tort insurance plans. As a recent Canadian study concluded:

If you sat down to design a system for wasting and dissipating precious medical and insurance resources, you could not do any better than what we have now.¹

The Trebilcock study came to the same conclusion:

Compensation administered through the tort system -- in large part because of the uncertainties entailed -- is appallingly expensive. Victims receive only a little more than 1/3 of the monies entering the system, compared to 80 or 90 per cent under most forms of first party or social insurance ... As a system of insurance or compensation, the current tort system is on most criteria, an abject failure.

In the personal injury area, tort should not be used either for deterrence or for compensation objectives. The former should be clarified and reinforced through a combination of regulatory initiatives at both the premium-pricing level (via a bonus-malus system described in more detail in Part C below) and at the public safety and Criminal Code enforcement level. The latter, compensation, should be dealt with separately in the context of a fair and more expeditious no-tort insurance system.

The importance of separating compensation objectives from quality-control concerns in the design of a modern health and safety program was stressed in a recent study that was conducted for the federal Department of Health and Welfare on the "Potential Effect of Liability Claims on the Canadian Public Health Care System".² The study examined the current crisis in the health care system and, in particular, the difficulties in the medical malpractice area: the changing nature of medical malpractice litigation, the increasing numbers of actions that are being brought against doctors, the spiralling increases in legal costs, and the growing delay in the processing and settlement of medical injury claims. The study concluded that "the civil liability system for the compensation of the disabled is cumbersome, complex and expensive" and urged that an alternative to litigation for the compensation of those disabled by medical injury had to be sought. The study said this:

¹ Belobaba study and references cited therein.

² Sellers study, attached in Appendix 17.

We should compensate the disabled regardless of how their disability was caused. We should ensure that their quality of life is maintained. ... The legal system does not ensure that the disabled are compensated unless negligence can be proved. As well, the tort system does not and cannot deal effectively with the health care professional who practices sub-standard care. Nor can it deal effectively with a negligent hospital or with negligence in the health products industry. ... the issue of compensation for the disabled should be clearly separated from the issue of the regulatory requirements for maintaining the standards of health care. ... An alternative to litigation for the compensation of the disabled has to be sought.

Towards a No-Tort System of Accident Compensation

The fundamental solution lies in recognizing that compensation and deterrence must be separated and that the compensation job must be done through a more efficient and equitable first-party no-tort accident insurance system. The modern-day problem of injury compensation should be dealt with more efficiently and expeditiously -- not through tort but through insurance. Whether the reforms proposed below are to be instituted incrementally or more generally is a matter that must be left for the legislature. The Task Force will set out its views on this matter in more detail below.

First, however, it is important to emphasize the following three points:

- (1) The design of the new insurance compensation system should proceed on a no-tort basis. This does not however mean a "no-fault" basis. Compensation, to be sure, will be provided on a "no-fault" basis, but fault will remain relevant and deterrence will be achieved through a more refined and rigorous penalty-rating or premium-pricing mechanism, as described earlier.
- (2) The delivery of the no-tort accident compensation system should remain primarily in the hands of the private insurance industry -- at least so long as private insurance can demonstrate that it has the financial capacity to design and administer such a scheme at affordable premium levels.

The basic scheme that is envisaged by the Task Force is a no-tort accident insurance policy designed and delivered by private industry, providing unlimited medical and rehabilitation benefits, including cost

of care, and income replacement care benefits at levels that would be reasonably adequate for the vast majority of Ontario citizens.

- (3) Additional coverage for income replacement benefits in excess of the basic insurance package would be obtained on a first-party basis, through the voluntary purchase of additional "layers".

To return then to the question of degree of implementation. The Task Force sees three basic choices once the principle of no-tort accident compensation has been accepted. They are as follows:

(1) No-Tort Injury Compensation for Automobile Accident Injury Only

This would involve the redesign of the existing and compulsory automobile insurance scheme by raising the no-tort or "no-fault" benefits to accommodate the basic principle developed above and then to provide for the purchase of additional layers for those individuals who choose to obtain excess coverage above the basic norm. The province of Quebec has had a no-tort automobile accident insurance plan in operation since 1978. However, it is important to note that the Quebec scheme is government-run. The Task Force believes that in Ontario the private insurance industry should have the opportunity to demonstrate whether and to what extent it can be counted on to deliver the insurance product.

(2) No-Tort Injury Compensation For All Accidents

In many ways this is the logical reform in the redesign of the Ontario injury compensation system. If workers' compensation remains as it is -- a government-run first-party no-tort compensation scheme, and if a no-tort automobile accident can be designed and delivered by private industry, then all that remains is an additional insurance dimension that would deal with the non-work, non-automobile injury. All accidents could then be covered.

The notion of a universal accident compensation scheme is not an unfamiliar one. New Zealand has had such a system since 1974 and by all reports it continues to operate efficiently, expeditiously and fairly. We have included a summary of the New Zealand system in Appendix 15 to provide readers with a better sense of what universal accident compensation would entail. However, here again, it is important to stress that unlike New Zealand, the Ontario compensation scheme would be designed and delivered by the private insurance industry.

(3) No-Tort Compensation For All Disability

This is really the logical extension of injury compensation -- the extension to include not just "accidental" injuries but indeed all disability -- accidental injury, sickness and disease. The literature has demonstrated that there is no principled basis upon which to differentiate accidental injury from congenital defects or disease-related disability.

There would certainly be considerable advantage to a comprehensive approach to the needs of those disabled by accident and disease. As set out in Appendix 16, the uneven, patchwork nature of the present system of disability benefits in Ontario is particularly disturbing. For some time now, officials of the federal and provincial governments have had ongoing discussions about the possibility of a comprehensive disability scheme. Phase I of the study was completed in 1983 and the First Report submitted to the Ministers of Social Services in September 1983. It outlined the serious problems with Canada's disability income protection system and possible options for reform. In the second phase of the study, the Task Force was asked to develop and cost specific models. The draft Second Report was completed in November 1985 and is now under consideration.

For all practical purposes, however, although a comprehensive disability program was endorsed by the recent Macdonald Commission, it appears that universal disability may have to await a much wealthier economic base for its implementation and also a complicated process of rationalization between federal and provincial authorities and private

insurers of the vast array of no-tort compensation schemes described earlier. In many ways then, universal disability compensation, although logically compelling, is realistically unattainable in the short to medium term.

The Task Force therefore recommends that:

- B.28 In the short term, a new accident compensation scheme should be implemented by the private insurance industry at least for automobile accident injury. (This proposal is developed in more detail in Part C below.)
- B.29 Ideally and as a medium-term objective, government should begin to work with the private insurance industry to design a universal accident compensation plan that would include compensation for all accidental injuries.
- B.30 Eventually and in the longer-term, federal and provincial governments should begin planning the co-ordination and rationalization of all existing first-party no-tort compensation schemes into a universal disability compensation program.

The Task Force recognizes that these recommendations will raise many questions about design and content. There will also be some opposition and objection in principle. However, most of the objections to no-tort compensation tend to disappear with explanation and education. Many of the questions have already been answered in the literature.

The Task Force has not examined every detail in the design or delivery of a no-tort accident compensation system but it is confident that these details can be worked out through good-faith effort and an open-minded attitude. The basic thrust of our reform proposal is this: an important solution to the liability insurance crisis is in the development of a no-tort system of accident compensation.

P A R T C

O T H E R

I N S U R A N C E

I S S U E S

PART C

OTHER INSURANCE ISSUES

I AUTOMOBILE INSURANCE

Introduction

The Task Force has set out in Part B its serious concerns with the equity and efficiency of the personal injury compensation system, and its conclusion that the modern-day problem of injury compensation should be dealt with more efficiently, more expeditiously and more fairly. It was also proposed that, at the present time, the first step towards such a system should take place in respect of automobile-related personal injury accidents. This part will elaborate on this proposal and other related recommendations.

One particular empirical observation is important at this point. There are signs of significant changes in the bodily injury component of the automobile insurance system, which give rise to serious concerns about its continued acceptability to the public and its affordability in the future if present trends are left unchecked. As indicated in the paper on "Review of Trends and Cycles in Availability and Price of General Insurance Services" in Appendix 7, although the frequency of bodily injury claims per insured car has in fact declined slightly over the last five years (1981-1985), the average cost of claims per insured car has steadily increased by an annual average of 14.8% over the same period, representing a real increase of 8.1% (after inflation). The increases are principally due to claims for bodily injury. The increase in costs appears to be concentrated in the smaller claims (less than \$50,000) since claims over \$50,000 have increased by an annual average of only 6.2%. In the Task Force's view, this steady upward drift must be addressed now. It reflects dissatisfaction with the accident benefit program, which is contributing to increased use of the expensive tort/litigation system. The cost of the system is increasing, a trend that may soon press against the limits of affordability and acceptability.

The discussion is arranged as follows. First, a brief description of the evolution of the automobile insurance system in Ontario is set out. Second, the proposals for fundamental change in the personal injury compensation system are put forward. Finally, the need to change the rate structure and rate

classification will be discussed, as well as the possibility of some form of systematic rate monitoring and surveillance, and various improvements to the marketing of the compulsory insurance product.

Evolution of the System of Automobile Insurance in Ontario

In order to describe the evolution of the system of automobile insurance in Ontario, it would be most useful to focus on the Standard Automobile Policy. This will facilitate an understanding of the extent of coverage currently available and the interface between compulsory and non-compulsory automobile insurance.

Section 201 of the Insurance Act provides that insurers shall use a uniform form of application, policy, endorsement or renewal certificate, as approved by the Superintendent of Insurance. The mandatory standard owner's form contains three broad sections. Each of these is discussed in turn.

Section A deals with third-party liability and provides for compensation to be paid to third parties. More specifically, it stipulates that the insured shall be indemnified against liability imposed by law for loss or damages arising from the ownership, use or operation of the automobile, and resulting from bodily injury to or the death of any person, or damage to property. It should be noted that the indemnity applies not only to the insured but also to every other person who, with his or her consent, personally drives the automobile.

This coverage was made compulsory in Ontario in March 1980, following the recommendations of the Select Committee on Company Law and the enactment of the Compulsory Automobile Insurance Act. As of March 1, 1981, the minimum compulsory coverage was increased from \$100,000 to the current level of \$200,000. It should be emphasized that this is the lowest limit that may be purchased, and consumers are urged to buy considerably higher amounts.

Section B of the Standard Automobile Policy deals with Accident Benefits Coverage. In fact, it is in substance a separate policy, being independently set out in Schedule E of the Insurance Act, and should therefore be read as an independent document. The benefits are payable to the insured

regardless of fault. The provisions were implemented on an optional basis in 1969, but were made mandatory in 1972 in all automobile insurance policies issued in Ontario that contained third-party liability coverage. The coverage was then enriched in 1978 to the current level of benefits noted in the following table.

**ACCIDENT BENEFITS
(SECTION B, STANDARD AUTOMOBILE POLICY)**

MEDICAL PAYMENTS	\$25,000 per person including rehabilitation, excluding Government Health Insurance Plans. Time limit: 4 years.
FUNERAL EXPENSE BENEFITS	\$1,000 maximum.
DISABILITY INCOME BENEFITS	80% of wages, maximum of \$140.00 weekly, 104 weeks temporary. Lifetime total and permanent first day cover. Non-contributory first 14 days. Unpaid housekeeper, \$70.00 per week, maximum 12 weeks.
DEATH BENEFITS	Death within 2 years after accident. Head of household, no age limits, \$10,000. Plus \$1,000, each dependent beyond first, no limit. Spouse, no age limit, \$10,000. Dependent child, \$2,000.

It should be noted that all provinces have now opted for some form of add-on no-fault bodily injury compensation, with the notable exception of Quebec, which has opted for a no-tort system for personal injury compensation. The accompanying chart sets out the comparative compensation schemes.

Note that Section B now includes mandatory uninsured motorist coverage. This provides coverage to the policy-holder in the event that he or she is injured through the fault of an uninsured motorist.

Finally, reference should be made to Section C of the Standard Automobile Policy, which provides for four different subclasses of coverage for loss of or damage to the insured automobile, from which the insured can make his/her selection:

Automobile Insurance

Canadian Automobile Insurance Plans (as of July 1, 1985)

109A

- Subsection 1 All Perils** - The insurer agrees to indemnify the insured against direct and accidental loss of or damage to the automobile, including its equipment, from all perils, as defined.
- Subsection 2 Collision or Upset** - The insurer's obligation is limited to loss or damage caused by collision with another object or by upset.
- Subsection 3 Comprehensive** - The insurer's obligation is limited to damage from perils other than by collision with another object or by upset.
- Subsection 4 Specified Perils** - The insurer's obligation is limited to damage caused by fire, lightning, theft or attempt thereat, windstorm, earthquake, hail, explosion, riot or civil commotion, falling or forced landing of aircraft or of parts thereof, rising water, or the stranding, sinking, burning, derailing or collision of any conveyance in or upon which the automobile is being transported on land or water.

Each occurrence, with minor exceptions, shall give rise to a separate claim, and the insurer's liability is limited to the amount of loss in excess of the selected deductible amount.

In any discussion of the evolution of the automobile insurance system in Ontario, mention must be made of a particularly important component of the current Ontario structure relating to compulsory automobile insurance -- the Facility Association. With the advent of compulsory automobile insurance in 1980, it was imperative to ensure that all drivers had access to the necessary insurance. Rather than adopt the "take all comers" principle advocated by the Select Committee whereby all insurers would have to accept all applicants, the Facility Association was created as a successor to the Facility. It is a non-profit organization comprising all licensed automobile insurers in Ontario who share the losses of the organization.

The principal purpose of the Association is to guarantee market availability upon payment of the premium to any licensed driver in Ontario who cannot obtain insurance through the ordinary market system. Insurance is placed through some eleven servicing carriers who are licensed insurers. The rates charged for business placed are uniform, and reviewed by the Superintendent. The coverages are such as to ensure the availability of automobile insurance as required by law. (Note that in December 1985, under special authority, the Association undertook to permit limits for third-party liability of up to \$5 million (U.S.) inclusive, to meet the special filing requirements of the United States Inter-State Commerce Commission with respect to Canadian Carriers.)

The primary users of the Facility Association have been high-risk drivers, including young male drivers. As noted above, during the recent hard market, it has become clear to the Task Force that an unusual number of drivers have been classed as unacceptable high risk drivers by insurers and have been directed to the Facility Association. This is a disturbing trend, and will be addressed in greater detail in the discussion of the proposed changes to the rate structure, possible forms of rate regulation, and improvements to the marketing of automobile insurance generally and the compulsory component in particular.

The foregoing discussion has sketched the evolution of the system of automobile insurance in Ontario. The next section will deal with proposals for fundamental changes to the personal injury compensation system.

Options for Reform of the Automobile-Related Personal Injury Compensation System in Ontario

As noted earlier, the Task Force is seriously concerned with the longer-term implication for the equity, efficiency and affordability of the present system, and of the steady upward drift in average settlements and awards for bodily injury.

The foregoing concerns have led the Task Force to question the efficacy of the current system of accident benefits. When accident benefits were first introduced, it was expected that with ready access to expeditious, up-front no-fault payments, accident victims would find it less necessary to resort to the expensive tort system. This clearly has not happened. Instead, the level of accident benefits has stagnated since 1978 and deteriorated substantially in real terms so as to provide very little incentive to innocent accident victims not to pursue their actions through the tort system. Indeed, the income replacement component has now fallen behind the minimum wage.

Special note should also be made of severe constraints often imposed on accident victims by the \$25,000 cap on first-party medical payments, including rehabilitation. In this connection, the Task Force notes that a number of groups

and individuals have made thoughtful submissions stressing the value of rehabilitation services in not only maximizing the recovery and well-being of accident victims, but also in minimizing expensive outlays for other types of medical expenses.

The Task Force has closely examined a number of options for reform to the personal injury compensation system with a view to improving both its efficiency and equity. Some of the experiences in other jurisdictions are set out in detail in Appendices 12, 13, 14 and 15. It is important to emphasize at this point that the Task Force will only address options to reform the bodily injury component of the automobile insurance system, and it is not proposing to make any alterations in respect of the property damage component at this time.

Based on this examination the Task Force has concluded that an essential element in the reform of the bodily injury component of the automobile insurance system is first-party insurance coverage. The foundation of any reform must be compensation for losses and costs due to bodily injury that meets the standards of the majority of the population fairly, efficiently, promptly, economically, predictably and with as little litigation as possible. The Task Force is convinced that the new system can be delivered privately by the general insurance industry subject to minimum guidance from government. The Task Force therefore recommends that:

- C.1 The Government of Ontario should work with the insurance industry to devise the framework for the private delivery of the new system of personal injury compensation recommended herein. Particular emphasis should be placed on ensuring the provision by the industry of adequate layers of first-party insurance coverage above the minimum mandatory compensation levels, as well as ensuring access to adequate rehabilitation services. In addition, the industry, with the assistance of the Government, should establish a pooling mechanism such as a catastrophic claims fund to ensure that all insurers, regardless of size, be in a position to meet their obligations to provide first-party coverage in respect of victims of catastrophic injury. The Facility Association can perhaps provide the necessary mechanism. Finally, the Government must ensure that the industry establishes adequate dispute resolution mechanisms, whether by way of expeditious arbitration or otherwise.
- C.2 The Government of Ontario should then introduce a mandatory system of auto insurance for personal injury compensation whereby all insureds purchase a basic minimum level of insurance including coverage for loss of income, costs of care, and unlimited rehabilitation and medical expenses. The minimum level for loss

of income should be set at a level such as to cover a clear majority of the population of Ontario, and should be subject to the appropriate cost of living indexation formula, and to an annual review by a committee of the Legislature. Where considered appropriate, insureds could purchase additional layers of income replacement coverage on an individual or group basis.

In establishing the appropriate basic mandatory compensation program, it would be desirable to establish a level such that a majority of the population in Ontario could rely on the automatic coverage, and would not have to purchase additional layers of insurance for income replacement related to bodily injury from auto accidents. In this connection, further study must be made of the income distribution in Ontario, but based on some preliminary research, the Task Force suggests that a mandatory first-party insurance coverage based on an income replacement compensation of net income up to the equivalent of a gross maximum weekly wage or salary of \$600 (approximately \$31,000 per annum) might be appropriate. Additional layers of income replacement could be available on an optional basis within first-party coverage in automobile insurance contracts. Other categories must be established such as to provide appropriate minimum levels of compensation to such persons as homemakers, children and students. Lifetime benefits would be provided, and would be adjusted to the degree of impairment of earning capacity, as appropriate.

One particular issue that must be addressed in connection with the provision of the costs of care of injured persons, particularly those who are seriously and permanently injured, is how to ensure that the design, administration and scale of benefits of the system, are sufficiently flexible to accommodate important social choices, such as those favouring home care over institutionalized care. The Task Force is of the view that this should be given close attention.

With respect to the other compensation components, the Task Force recommends unlimited rehabilitation and medical benefits. The Task Force has been much impressed with the value and cost-effectiveness of rehabilitation. Moreover, drawing on the experience in Michigan in particular, as described below, unlimited benefits can be handled by the private industry, in conjunction with a catastrophic claims fund to spread the risk. A 1982 study in Michigan perhaps demonstrates this value most succinctly with the following observation:

"Recent estimates have shown that for every dollar spent on rehabilitation, nine dollars are returned through increased productivity and that for every rehabilitated spinal cord injury, \$60,000 in future medical and nursing home costs are saved. However, a successful rehabilitation is generally possible only if an individual gets appropriate treatment as soon after the accident as possible. Placing a ceiling on Personal Injury Protection payments will serve to introduce uncertainty for the injured individuals on whether or not he or she can afford rehabilitation treatments. This uncertainty inevitably causes delay and markedly reduces the possibility of successful rehabilitation."

With respect to the private delivery of any new system of personal injury compensation, the Task Force is convinced that the private general insurance industry is ready, willing, and able to provide the necessary first-party coverage -- both the mandatory minimum component and the subsequent layers of coverage -- tailored to an individual's personal income circumstances. In this connection, it is interesting to note that in Quebec, where a no-tort compensation system is already in place, the private insurers provide supplementary disability insurance on an individual or group basis beyond the minimum coverage provided by La Régie d'assurance automobiles. In addition, they stand ready to supply the minimum mandatory coverage as required by the government, should the government decide to spin off this function from La Régie.

Certain areas would of course require special attention. For example, the government must be vigilant and ensure that adequate rehabilitation services are provided by the private sector. In this connection, the Task Force has been made aware of the already substantial private sector involvement in the provision of rehabilitation services at the present time.

Insurers must also be required to establish expeditious and fair internal arbitration procedures to deal with unsatisfied insureds, perhaps similar to the procedures set out in Section 125 of the Insurance Act in respect of fire insurance. (See also Section 207(8) in respect of disagreement over appraisals in respect of automobile accidents.) Indeed, it is interesting to note that as early as 1979, the Select Committee recommended the extension of this access to arbitration to all kinds of property and casualty insurance. Many others have recommended greater use of the Arbitrators' Institute of Canada Inc. In any event, there is certainly no compelling reason at this stage for a publicly established administrative review system such as the Workers' Compensation Board and the recently created Worker's Compensation Appeal Board.

Nonetheless, the situation must be monitored closely.

In addition, consideration must be given to the integration of the private insurance benefits with the panoply of available public benefits. For example, at present, under a special agreement with the Ontario Health Insurance Plan, most but not all insurers have arranged to compensate OHIP according to a pre-established formula, in return for which OHIP has given up its right of subrogation. This, however, applies only to motor vehicle accidents where the wrongdoer is insured. If the wrongdoer is uninsured and a claim is asserted against the victim and insurer pursuant to the uninsured motorist cover, OHIP still has the right to assert its subrogated interest. Certainly, new arrangements with OHIP must be worked out as part of any new compensation scheme for victims of automobile accidents.

More generally, however, a more rational approach to resolving the variety of subrogated interests is required in order to enhance the efficiency and equity of the new compensation system. This will involve an examination, among other things, of the Vocational Rehabilitation Program operated by Ontario's Ministry of Community and Social Services to assist in modifications to the home and workplace; prosthetic devices and retraining; the Residential Rehabilitation Assistance Program operated by Canada Mortgage and Housing Corporation for home modifications; the assistive devices program of the Ministry of Health of Ontario, which pays approximately 75% of the assistive devices for persons 21 years of age or younger; Unemployment Insurance; and the Canada Pension Plan. The subrogated interests of the Vocational Rehabilitation Program as well as the CHAMP Program sponsored by the War Amputations of Canada must also be considered.

Finally, in concluding this discussion of the private delivery of the new compensation system, mention must be made of the need to assist the industry in forming a pool to spread the risks of catastrophic claims. This is an essential mechanism in order to ensure that the obligation to provide unlimited rehabilitation and medical benefits does not impose an excessive and unfair burden on small insurance companies that happen to have insured persons who suffer catastrophic injuries.

Such an industry association has been successfully formed in the state of Michigan. All automobile insurers are required to be members. The association is directed to indemnify insurers for all losses that are expected to exceed \$250,000 and to "calculate and charge to members of the association a total premium sufficient to cover the expected losses and expenses of the association", according to a statutory formula. The structure and operation of the Association are set out in detail in Appendix 14. Conceivably, Ontario could draw on this experience and that of the Facility Association to create the necessary mechanism.

Consideration must also be given to the so-called "pain and suffering" or non-economic component of damages. As has been emphasized in Part B above, there is already a firm cap on such damages imposed by the Supreme Court of Canada -- \$100,000 in 1978 dollars, now approximately \$184,000. It must be noted that a component for pain and suffering could be built into the basic compensation system, if considered desirable by the government, and then purchased as part of the additional layers of protection. The point should be made, however, that most commentators in the personal injury compensation literature discouraged the addition of any non-pecuniary item to an injury compensation plan. The matter remains controversial and will undoubtedly have to be resolved in due course, as the no-tort insurance plan takes shape.

The Task Force is convinced that such a new system of personal injury compensation would meet the standards set out above. It should go a long way toward reducing the trend toward litigiousness -- toward no-tort or limited use of the tort system for compensation for bodily injury from auto accidents. But in view of the fundamental distortions, inefficiencies, inequities and lottery nature of unrestrained use of the tort system in this field, the government should consider limitations on its use. The Chairman's preference is for a no-tort system in this field as set out in recommendation C.3, but he recognizes that the threshold limitation set out in recommendation C.4 may be more acceptable at this time, even though he considers that it would be inequitable. The Task Force therefore recommends that:

- C.3 The Government of Ontario should consider elimination of resort to tort/litigation system with respect to personal injury compensation from automobile accidents; or
- C.4 The Government of Ontario should consider substantially limiting resort to the tort/litigation system with respect to personal injury compensation from automobile accidents, by way of a threshold.

The basic case for substitution of a compensation and deterrence system for the existing tort/litigation system has been set out in Part B of this Report. More efficient and equitable systems are available. A compensation system such as the one described above, together with the deterrence and incentive system discussed below, is likely to be a more appropriate framework within which to deal with bodily injury from auto accidents for the decades ahead.

It is important to recognize the accomplishments of the tort/litigation system as it has evolved in Canada and in Ontario during the last few decades. It has played a leading role, often in spite of rather than with the help of governments, in adapting the standards and ranges of application of compensation for bodily injury to the needs and capabilities of society. It has interpreted the changes in social values and applied them to individual cases. It has reflected society's changing preferences for home over institutional care for some severely and permanently injured persons. It has interpreted changes in standards of living in adjudicating income replacement and supplementation. It has established what society appears to consider reasonable standards for non-economic damages, such as pain and suffering. It has promoted high standards of professional conduct.

Why then consider eliminating or limiting the resort to the tort/litigation system for bodily injury arising from auto accidents? First, there are signs that it is deteriorating; that it has had to try to accomplish too many objectives with too few instruments. Second, there are signs of increased litigiousness in society, particularly regarding bodily injury from auto accidents, which may not be adequately discouraged by the new system of personal injury compensation recommended above. Third, the system is not now able to deal with the accident injury compensation in a principled, consistent way, for reasons set out in Part B of this Report.

Having said this, however, if the decision is nonetheless made to preserve the tort/litigation fragment for use in special circumstances, the difficulty remains in designing the appropriate "threshold". Should it be a "monetary" threshold that would permit litigation when actual or anticipated income losses exceed those offered under the basic insurance plan? Or should it

be a "verbal" threshold that would attempt to reserve access to tort for those cases where serious injury has resulted in "loss of a bodily function or permanent disfigurement"? Both of these approaches present further difficulty. If the threshold is a monetary one geared to excess-income claims, does it make sense to retain the tort vehicle for these situations? The only persons who would resort to lawsuits for these excess economic claims would be those who had chosen not to purchase additional layers of coverage. If this is so, would there not then be cross-subsidization of the higher-income earners? And if a verbal threshold is employed so that non-pecuniary recovery can be obtained for the permanently disabling injury, does it make sense to preserve tort litigation, given the "cap" on pain and suffering, and given that in any event this item of intangible injury could be made a component of the basic first-party no-tort insurance package?

The Task Force raises these concerns because it recognizes that a number of American states have opted for a "modified" tort/no-tort system for automobile injury compensation. These states have done so, however, in the context of an American court system that presently allows an unlimited recovery for intangible losses such as pain and suffering. This is not the case in Canada. Thus, any discussion in the Ontario context of the value of "modified" tort and the viability of a "threshold" should understand this difference in our law, and should address the questions raised above.

The Task Force is convinced that incentives to for good behaviour and penalties or deterrents for bad behaviour should be a part of the auto insurance system. These should involve the implementation of a bonus-malus system, safe driving campaigns, better safety standards and equipment, and stricter criminal code sanctions, and also changes to an integrated data base relating to driver claims' histories and convictions records, and to permit insurers to have access to this information on an on-line basis. Accordingly, the Task Force recommends that:

- C.5 In conjunction with the introduction of a new system of personal injury compensation, the Government of Ontario should work with the insurance industry on an urgent basis to enhance the deterrent to hazardous driving, and to implement an effective bonus-malus system for setting automobile premium rates. At the same time, the Attorneys-General of both Ontario and Canada should be strongly encouraged to continue their efforts to ensure more appropriate criminal penalties in respect of unsafe driving.

- C.6 To ensure the effectiveness of the bonus-malus system, the Government of Ontario should work with the industry to devise a plan to create an integrated data base to provide drivers' claims histories, conviction records and driving experience, and explore how to make this essential information available on an on-line basis.

With respect to the bonus-malus system, it would be useful to first set out some background to the bonus-malus systems now in existence, with particular reference to the claims-rated system so successfully implemented by the Insurance Corporation of British Columbia. It will then be possible to put forward some recommendations for appropriate reform in Ontario.

Since the 1960s, a number of European countries have developed, as part of the automobile rating system, a bonus-malus system designed to reflect the claims recorded against a vehicle. The bonus, or merit factor, is a premium discount the insured is entitled to if no claim is made in the policy period. The malus, or demerit factor, is a premium increase charged as a result of a claim made during that period.

The key elements of the system are illustrated by examining the table used in Switzerland, as follows:

Bonus (Discount)	Entry Point														(Surcharge) Malus							
Step	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
%	50	50	60	60	70	70	80	80	100	100	120	120	140	140	170	170	200	200	230	230	270	270

The system considers claims against the policy, regardless of the driver of the vehicle. A new owner enters the system at Step 9 (100%) and moves down the scale (bonus) for each subsequent claims-free year, with a premium reduction at two-year intervals. For each claim reported, the insured regresses (malus) by three steps and the renewal will be subject to the appropriate differential, e.g., one claim, 140%, two claims, 170%. The increments on the scale are arbitrarily established by the regulatory authorities and not actuarially cost-justified.

There are some who doubt that a similar system could be adapted to the Canadian market as it exists today. First of all, there has to be complete co-operation on the part of insurers to voluntarily exchange claims information, so as to prevent an insured person from obtaining a more favourable position on the

scale by changing companies and withholding historic information. In Switzerland there are only twenty-six companies, with four of them writing 60% of the business. In Ontario there are over a hundred companies competing for the available business, with no one predominant company in the market. The Task Force believes, however, that both these objections can be overcome through the appropriate design of the Ontario system as set out herein.

The ICBC claims-rated scale provides the most useful model for Ontario and should be set out in some detail. As of January 1, 1983, premiums for ICBC Autoplan coverages were charged according to a Claims-Rated scale of discounts and surcharges. (Note that in British Columbia, the insurance renewal is payable at the same time as the motor vehicle licence renewal, and the decal and insurance certificate are both issued by the ICBC Autoplan Agent or Motor Licence Office.)

The features of the claims-rated scale are as follows:

- o Each Third-Party Liability and Collision claim for which a payment is made moves the vehicle owner's premium three steps up the scale. There is no limit to the number of steps, or levels, above the base rate.
- o Each claim-free year moves the vehicle owner's premium one step down the scale until it reaches the fourth and lowest level of discount.
- o As an incentive for improvement, where a premium is still above the base rate after three consecutive claim-free years, it will be returned to the base rate.
- o Introduction of a "forgiveness" feature, which means that where liability in a claim paid in 1986 is 25% or less, the premium will not be increased.
- o The position on the Claim-Rated Scale is not affected by claims for No-Fault Accident Benefits, hit-and-run, windshield, theft, or vandalism claims, or any other loss paid under Comprehensive, Specified Perils, Underinsured Motorist Protection, loss of Use coverage, or claims for loss under \$10.
- o Responsibility for the use of a vehicle remains with the owner, whether it is driven by the owner or by another person with the owner's permission.
- o A driver or vehicle owner coming from outside the province is required to verify eligibility for a discount or enter at the base rate. Verification requires the insured to make a declaration and to present documents from prior insurers showing claim status for the previous four years.

In investigating the system of automobile insurance in British Columbia, the Task Force was particularly impressed with the effectiveness and efficiency of the claims-rated scale. There appears to be no reason why a similar system could not be equally successfully implemented in Ontario.

The Task Force notes, however, that the success of the ICBC system is due in large measure to the comprehensive data base to which all brokers have access; the fact that insurance renewal is linked to motor vehicle licence renewal; and that the decal and insurance certificate are both issued by the ICBC Autoplan Agent or Motor Licence Office. In the Task Force's view, it is entirely feasible to introduce a similar link between vehicle registration and automobile insurance in Ontario at this time, given that auto licensing is now changed to associating licence plates with owners rather than vehicles.

Moreover, it will provide the key element in the development of an integrated data base -- something that is critical as more and more emphasis is being placed on driving record and experience for premium rating criteria. In this connection, the Task Force is well aware of the less-than-adequate state of the automobile industry data bases and access to claims information and conviction records. For example, the Task Force has been informed that automobile insurers face delays of up to six weeks in obtaining motor vehicle abstracts from the Ministry of Transportation and Communications. This is totally unacceptable.

Fortunately, some steps have been taken toward the eventual implementation of a 24-hour "tape to tape" exchange between insurers and MTC. In late fall of 1985, a successful pilot project was undertaken by Royal Insurance Canada and the Ministry. A more extensive implementation of this project has not been forthcoming, perhaps pending clarification of the insurer's right to the necessary information under the proposed "Freedom of Information and Individual Privacy Act", although individuals do consent to the insurer's access to this information when they complete their application for insurance.

In addition, several significant developments in respect of industry data bases were announced in March 1986. In particular, the Insurers' Advisory Organization has received a couple of proposals to develop and implement an

automobile claims tracking data base and reporting service that would track automobile insurance claims by drivers' licence number. Subscribers to the system could access the system, which would report the claims history of the driver. Insurers would be able to obtain this information quickly, without searching loss histories with other companies, and could readily identify false or misleading applications. It is understood that the IAO has approved the proposal and the concept in principle, and that implementation appears to be contingent upon further investigations of the cost.

In addition to a bonus-malus system and the related data base proposals discussed above, much more emphasis must be placed on initiatives such as safe driving campaigns, driver education courses, the use of safety equipment such as seat belts, special children's car seats, and so forth. In this connection, the experience in British Columbia is again encouraging. The ICBC has put a great deal of effort into a "buckle-up" campaign, and nearly 75% of British Columbia drivers use seat belts compared with an average of 63% for all eight Canadian provinces with seat belt legislation. Statistics now prove that the use of seat belts has reduced traffic fatalities by at least 60%. And for every 1% increase in seat belt use across British Columbia, deaths and injuries are significantly reduced, resulting in a community cost savings of \$1.35 million per year.

Finally, the Task Force welcomes and encourages the recent efforts of both the provincial and federal Attorneys-General in strengthening the criminal code sanctions against dangerous driving. This already has had and will continue to have a beneficial impact on the safety on our roads and reduce the probability of automobile accidents.

Automobile Rate Structure

The primary issue that has arisen in respect of the automobile rate structure in Ontario is the question of classification by age, sex and marital status. This will therefore be addressed in reasonable detail. In addition, the Task Force has been made aware of many other instances of contentious rating practices, such as that of linking premiums for close relatives even if they drive different cars, and that of very high premiums charged to parents of children

under 22 years of age who may drive the family car. The rationale for such practices seems to be the fact that insurance companies provide coverage to anyone driving the car with the owner's permission. Therefore, insurers understandably insurers want to ensure that all potential drivers have good driving records. Note also that, since the Highway Traffic Act makes the owner liable for the negligence of the authorized drivers of the vehicle, without third-party insurance every owner would be at risk.

The Task Force recognizes the serious concerns that such rating practices have elicited on the part of the public, and urges the Superintendent of Insurance to work with the insurance industry in seeking out the appropriate means to address the complaints. The root of many of the problems, however, lies with the questionable use of age, sex and marital status classifications, a subject to which the discussion will now be directed. The current classification system for automobile premiums has evolved in a complicated fashion. Currently there are no less than fourteen different classifications of drivers. Both insurers and actuaries insist, however, that this is entirely consistent with and justified by the evidence of the statistical probability that certain classes of drivers are more likely to be involved in an accident.

Discussions on whether or not to develop alternative rating criteria to eliminate those of age, sex and marital status have been ongoing for some time. The Select Committee on Company Law put forward its recommendation for the elimination of these criteria in 1978. Since that time, British Columbia, Saskatchewan, Manitoba and Quebec (at least in respect of bodily injury) have taken steps to eliminate the classifications.

On January 1, 1985, the Statistical Plan, prepared by the Insurance Bureau of Canada at the instruction of the provincial Superintendents of Insurance, was amended to begin the collection of certain alternate data. This Plan captures automobile insurance data for all Canadian jurisdictions other than those provinces with public automobile insurance systems. Because of the need to obtain the concurrence of all the provincial superintendents on the matter, it is clear that some passage of time may be required to implement this recommendation. Indeed, the industry argues that it may be 1990 before the industry has statistics that are sufficiently credible to formally delete age, sex and marital status criteria. However, it is highly likely that a variety of legal challenges will not countenance such a delay.

For example, the consensus of opinion appears to be that the use of the gender criterion by public bodies subject to the Charter infringes the Charter of Rights and Freedoms and is open to successful challenge. The use of the age criterion was successfully challenged under the Ontario Human Rights Code in the recent case of *Bates v. Zurich Insurance Company*. The case is presently under appeal.

Regardless of the legality of the particular criteria, it appears clear to the Task Force that age, sex and marital status have outlived their usefulness as surrogates for the degree of risk or hazard that persons impose on the system. Instead, the focus should be placed on driving records, driving experience and perhaps mileage as more logically supportable alternatives. In this connection, it is useful to note that both the Superintendent and the Facility Association are not opposed to replacing age, sex and marital status criteria as soon as adequate alternative criteria can be found.

The Facility Association anticipates major difficulties in considering alternative criteria such as driving experience because of the difficulty in obtaining information on accidents and convictions for 16- and 17-year-olds as a group, due to the Young Offenders Act. Yet the Facility Association could be required to lead the way in Ontario in dealing with this issue if, due to its being regulated by the government, it is forced to comply with the Charter.

It should be noted parenthetically that, to its credit, the Facility Association does build in a small discount for young drivers that offsets the higher premium to some extent. More specifically, private passenger vehicle premiums include a 9% commission for male drivers aged 16 to 22, and an 11% commission for all other classes. Similarly, the IAO advises that its rates for classes 10, 11 and 12 (unmarried male, age 16 to 18, age 19, 20 and age 21, 22) - the three highest risks in their manual -- include a lower level of expense loading. IAO rates for these classes only allow a 10% commission and they deduct 2% from company operating expenses. In a recent filing, the expense loading for these classes was 23.3% compared to 27.5%, or about 15% less than all other classes. The Task Force has been informed that most insurers have adopted this procedure.

In light of the foregoing discussion, the Task Force recommends that:

- C.7 The Superintendent of Insurance together with his counterparts on the Canadian Council of Superintendents of Insurance should take the necessary action to ensure that all automobile insurers in the various jurisdictions comply with the reporting requirements under the Statistical Plan as amended on January 1, 1985.
- C.8 The Government of Ontario should encourage its provincial counterparts to support a uniform date between January 1, 1989, and September 1, 1989, for the implementation of the elimination of age, sex and marital status criteria. This should give the industry adequate time to collect and analyze data, and be ready to apply appropriate alternate criteria.

Rate Regulation

The Task Force has emphasized that the primary problem in the automobile insurance market is that of affordability as opposed to availability, and that fundamental change is required in respect of the bodily injury component of the insurance premium as distinct from the property damage component. Many of the recommendations in the preceding sections will, the Task Force believes, cumulatively promote the objective of a more cost-effective and equitable automobile insurance system leading to better service, lower premiums, or both. For example, the adoption of a no-tort system for bodily injury is demonstrably cost-effective. In addition, the eventual elimination of age, sex and marital status classifications and the adoption of an effective bonus-malus system will ensure that the burden of higher premiums is placed on the truly high-risk drivers.

The possibility of a broader government presence in rate-making must now be briefly addressed. This is dealt with in detail in Part D in the context of proposals for a more systematic evaluation, monitoring and surveillance of rates in all lines of general insurance, not simply automobile. This section will deal only with certain observations relating to compulsory automobile insurance. In this connection, the Task Force believes that stronger powers of rate regulation in respect of the Compulsory Automobile Insurance Act would be appropriate at this time. A little background to recommendations in this area would be useful.

The Compulsory Insurance Act gives the Superintendent the power to approve or disallow rates for the residual market that are not in accordance with statistical evidence, experience or other justifiable factors, by-laws, and articles of the Facility Association. The Act defines the Facility Association and authorizes it to establish a plan of operation to include the compulsory third-party liability and accident benefits coverage as well as the non-compulsory coverage. Officials in the Office of the Superintendent have taken the position that they have the authority to approve all rates filed by the Facility Association, not only the rates for compulsory coverage, and in fact are acting on this basis. Their view is that the plan of operation must be changed to exclude non-compulsory coverage in order for them to confine their regulatory scope to compulsory coverage.

No similar authority for the Office of the Superintendent is contained in the Insurance Act since Sections 369-371 of the Act have not been proclaimed. Accordingly, for the segment of the compulsory automobile insurance that resides in the voluntary market, the Superintendent's role is limited to the monitoring of market conduct by responding to specific complaints, and the Office relies on competition as an effective regulator.

In the practical application of the Superintendent's powers to approve rates for the Facility Association, the approval process is slow as it requires public notice and a hearing, and the preparation reflects a shortage of casualty actuarial skills. The delays have a significant financial impact because the lower rates are used for an extended period of time which is now up to four months.

There appears to be confusion about the extent of the Superintendent's authority over the non-compulsory coverage offered by the Facility Association to the residual market. To address this, the Task Force recommends that:

C.9 The Compulsory Automobile Insurance Act should be amended to clarify and extend the Superintendent's regulatory power to the non-compulsory component of coverage in respect of both rate levels and classifications and surcharges used by the Facility Association.

More generally, the Task Force is also of the view that the public is not yet able, as it should be, to obtain the compulsory insurance product at the lowest possible cost. One change that might ensure the availability of at least

compulsory insurance at the lowest cost would the establishment of a mandatory basic rating classification system as recommended by the Select Committee in 1978. This of course would have to be examined in conjunction with the above recommendations for elimination of age, sex and marital status classifications. To date, such a broad-based scheme has been strongly resisted.

The Task Force has concluded that the establishment of a mandatory basic classification system, at least with respect to compulsory automobile insurance, would be a valuable step to take at this time. It is therefore recommended that:

C.10 The Superintendent of Insurance should undertake immediate steps together with the insurance industry to explore the implementation of a mandatory basic classification system, at least with respect to compulsory automobile insurance, with a view to its broader application if appropriate. This would take place in conjunction with the elimination of age, sex and marital status criteria as recommended above.

Self-Insurers and the Compulsory Automobile Insurance Act

The Task Force was directed by the Minister of Consumer and Commercial Relations to consider the request of the Municipality of Metropolitan Toronto for an amendment to the regulation under the Compulsory Automobile Insurance Act to exempt any municipality which maintains self-insurance from the requirements under the Act.

To meet the legislative requirements of the Act, every operator of a licensed vehicle must carry a motor vehicle liability insurance card as evidence of insurance. In order to comply, the Metropolitan Corporation obtained a Standard Automobile Policy from a licensed insurer for automobile insurance coverage. The Corporation also entered into an indemnification agreement with the insurer, which included provision for the repayment to the insurer of the full amount of every claim paid by the insurer under the policy. In effect, therefore, the Corporation is self-insured.

The Compulsory Insurance Act permits any person or group of persons to be exempted from the provisions of the Act subject to such conditions as are set out in an appropriate regulation. One exemption has been made with

conditions requiring a plan for financial responsibility, an appointed administrator, an undertaking to pay claims to the same extent as an insurer, and for the issuing of a certificate of insurance.

The Task Force has considered the request by the Municipality for a similar exemption in the light of the current capacity problems in the Ontario insurance market and, in particular, in view of the provincial initiatives to promote self-insurance through reciprocal insurance exchanges.

The Task Force is of the view that municipalities and other public authorities in Ontario have the resources and expertise to establish a plan for self-insurance with suitable administrative and financial guarantees for the payment of claims. The Task Force therefore recommends that:

C.11 Municipal corporations and other public authorities in Ontario that establish, either on their own or with other municipal corporations or public authorities, an adequate plan with appropriate financial guarantees to the satisfaction of the Ministry's officials, should be entitled to apply to the Minister for the appropriate exemption from the Compulsory Automobile Insurance Act, and that the terms of the plan, as approved, should be set forth in the exempting regulations.

Addendum: Commercial Vehicles

This discussion of the automobile insurance industry must not be viewed as restricted to personal lines. Rather, the Task Force believes that commercial vehicles such as taxis, truckers, rent-a-car fleets, motor coaches and so forth will also benefit from the recommendations set out above; notably, those in respect of the new no-tort personal injury compensation scheme. Vehicles crossing the border into the United States will, of course, continue to encounter serious problems of affordability and perhaps availability, but this issue is dealt with in greater detail above in Part B in respect of the liability insurance crisis.

II PERSONAL AND COMMERCIAL PROPERTY INSURANCE AND OTHER LINES

The personal and commercial property insurance market has certainly not encountered the same degree of structural and cyclical pressures as the liability insurance sector. Nevertheless, the unusually hard market we have

experienced has clearly had adverse spillover effects on property insurance and other lines of general insurance. The following discussion highlights the main problems encountered by insureds in this area, and puts forward certain recommendations to address them.

Personal Lines

Personal lines insurance includes homeowners' policies, tenants' packages, and condominium unit owners' policies, together with ancillary coverages to protect specific articles and needs. It also encompasses personal liability insurance, to protect individual consumers against occupiers' liability claims and so forth.

The Task Force is aware of the need for an adequate supply of reasonably priced coverage to protect an individual's investment in both real and personal assets. There is no evidence that such insurance is not readily available throughout the province and that a relatively stable market exists with no apparent capacity problems, other than those associated with specific insurers. Moreover, in comparison to liability insurance, property insurance is clearly viewed as a "safe", desirable line of business. Consequently, there is a high degree of competition in terms of both rate and coverage, and affordability is not a major problem.

The Task Force's concerns are therefore rather limited and relate to certain questions of availability and adequacy of property insurance. For example, individual insurers may decline to provide insurance on an older dwelling regardless of its condition or completed renovations. This increasing selectivity by age appears to restrict the availability of insurance in the older sections of cities and small towns of the province.

In 1965, the Fire, Housing and Legislation Committee of the City of Toronto dealt with similar complaints about the lack of availability of insurance for downtown residential properties. In response, the Department of Insurance

and insurance industry representatives established a set of guiding principles, stating in part:

- (1) "Rejection of an application or cancellation or refusal to renew a policy because of the physical condition of the property shall not occur without prior inspection of the premises."
- (2) "If the property is not insurable because of physical hazards, the owner will be advised by the company, its agent, or its inspector of the specific improvements or repairs that are required to meet reasonable underwriting standards."

These guiding principles provided an effective antidote to the problem that existed at that time. It now appears that the current trend towards "redlining" by insurance companies is increasing to the detriment of the consumer, and requires a similar response. The Task Force therefore recommends that:

C.12 The guiding principles of the Industry/Government Committee should be reaffirmed and circulated periodically, to remind those in the insurance industry of their obligations with respect to the rejection of an application or cancellation or refusal to renew a policy because of the physical condition of the property, and that indiscriminate rejection of insurance applications by reason of area be discontinued.

Another concern of the Task Force is with the adequacy of coverage. To begin with, there is no single standard policy for personal property coverage in the insurance industry. Each insurer markets its own range of products, providing a multitude of differing forms of protection. While this provides a wide variety of choice for the consumer, it makes it difficult for that consumer to comparison-shop in any meaningful way. In addition, the diversity of coverages creates problems in producing meaningful statistical data by the industry as a whole.

Most personal lines policies providing coverage on buildings or dwellings are written on a homeowner's form. This may be on a "named-perils" basis or on an "all-risk" basis, with little uniformity between the products offered by the various insurance companies active in the province. The premium for such policies is a set premium based on the amount of building coverage, and is not built up from the various components of the policy. This has created difficulties in attempting to establish a breakdown of the premium. Most insurers insist

that coverage on a building be maintained to a set percentage of the replacement value of that building.

Many insurers now offer guaranteed replacement endorsements, which protect the consumer in the event that the valuation placed on the building is incorrect. This endorsement ensures that replacement of the building in the event of serious loss will be on the basis of the replacement cost, irrespective of the amount of insurance carried on the building.

In an attempt to encourage a greater choice of options for the insured, the Select Committee on Company Law in 1979 suggested a core coverage as a standard coverage to be offered by all insurers -- either as a separate policy or as a component of a wider "package" of coverage. The Committee suggested that the core coverage might be defined as "coverage on the dwelling against fire and all major perils currently provided for in the majority of homeowner's policies, and full-replacement cost coverage on the dwelling with no upper limit on recovery or, alternatively, a high upper limit -- say \$250,000." Further coverages related to protection against liability or contents losses could also be incorporated into the core, if the industry were satisfied that the formulation of these coverages met the needs of a majority of policyholders. It was expected that this concept would aid in the provision of rating data on a more usable basis, as well as providing the consumer with an opportunity to obtain and compare quotes from a number of insurers on a uniform coverage basis.

In its submission to the Task Force, the Consumers' Association of Canada objected specifically to the indivisibility of the coverages and premium in the homeowners' policy. It was argued, for example, that the coverage provided for "outbuildings" or "detached private structures" may not be required and ought to be optional.

The Task Force considers this to be a valid concern and recommends that all insurers consider the provision of composite dwelling policies that allow individual consumers the choice of coverages that they feel they require. The Task Force further believes that it would be useful for the insurance industry to seriously consider once more the Select Committee proposals, and accordingly recommends that:

C.13 The insurance industry should seriously consider, on an urgent basis, ways to provide a greater choice of options and flexibility to both the homeowners' and the tenants' package policies.

Commercial Lines

The reluctance or, in some cases, inability of individual insurers to underwrite commercial property insurance is perceived by the Task Force as being of greater concern than in personal lines. There are some areas where there are only a limited number of markets available; in other areas, individual insurers have retired from writing what to them had been traditional lines; while in yet others, insurers have re-underwritten their entire books of business. All of these, together with price increases, have caused the number of submissions to insurers to increase significantly.

In general, the Task Force has not observed a special problem with availability, although admittedly insurers are placing significantly greater importance on the inspection of individual risks and compliance with subsequent recommendations. This is particularly true with respect to contracts written on an "all-risk" basis where there is, for example, a growing insistence on adequate security systems for most classes of business, depending upon their susceptibility to crime losses. This of course is not an undesirable development. But, though the overall capacity of an insurer has not been reduced, some are limiting growth in particular areas through selective underwriting by class rather than by specific risk.

With respect to the question of affordability, while there have been increases in the costs of commercial property insurance, excluding liability premiums, the Task Force has found that the increases are not extreme. There are of course some exceptions to this generalization, particularly where a policy is moved from the normal market to the residual market. It should be noted parenthetically that the Insurers' Advisory Organization has developed a simplified and more accurate national schedule for property insurance, which allows changes in rates to be more responsive to statistical changes than in the past.

Other Lines

The unfavourable loss experience in commercial insurance is reflected in tighter underwriting with respect to other lines of insurance, including crime insurance, cargo insurance, and the traditional inland/marine coverages. In certain specific areas, such as furriers, jewellers, and contractors, there has been a reduction in the number of markets available in the province. There has also been a gradual worsening of the loss ratio in the surety field. It is understood that this deteriorating situation is under review, and it is hoped that it will soon be corrected.

Aviation insurance suffered the worst year ever for losses in 1985, and it is expected that this adverse loss experience will result in sharply increased rates.

III DISTRIBUTION SYSTEM

The distribution system in Ontario is dominated by the independent brokers and agents who account for about 80% of the market, compared to some 20% for direct writers such as Allstate, State Farm and The Co-operators. (Note that the direct writers insure 25% of private passenger vehicles.) The Task Force has closely examined this system and the extent to which it has aided or abetted the insurance crunch. Although it is clear that the system has served the province well in the past, as reflected in the 1979 Select Committee Report, it is the Task Force's view that it has not been sufficiently responsive in dealing with the major structural and systemic changes that underlie the current crisis. Significant changes are now required in order to maximize the efficient utilization of capacity in the industry, and to adequately service the public needs and demands for new and more complex insurance products and a more stable risk environment. Such changes will be discussed here, as well as in the "Market Regulation" portion of Part D.

To begin, a brief background to the distribution system in Ontario would be useful. The distribution system in Ontario is split into two distinct segments. One segment is comprised of so-called "captive" agents. These are usually employees of a single insurer referred to as a "direct writer". The other segment is comprised of brokers -- independent businesspersons who arrange

insurance on behalf of a number of insurers. They are generally regarded as acting on behalf of, and owing a fiduciary duty to, the insured. Moreover, the Registered Insurance Brokers of Ontario Act, under which general insurance brokers have been self-regulated since 1981, specifies that its members not be involved with any business that would put them in a position to unduly influence the consumer to do business with them.

Most observers will admit that there is a place for both the captive agent and the broker. Captive agents understand the products they sell very well, and they are, in essence, salespersons. They sell a relatively limited range of products, while service is generally provided by the insurer.

In contrast, brokers spend less time in sales. On average, due to the scope of their business, they are not as familiar with all the individual products of each insurer. On the other hand, they have a broader knowledge of a wider range of products. The brokerage system is oriented towards service, as opposed to sales. The ability of brokers to access a sufficient number of insurers has become critical as insurers have become more selective in terms of the range of insurance products offered.

In describing the current distribution system, one cannot ignore the recent trends relating to the emergence of the "financial services" industry -- trends that might have the potential to have reasonably dramatic effects on the costs of delivering personal lines insurance to consumers. In theory, the "financial services" supermarket offers one-stop shopping for a variety of financial services products such as automobile, homeowners', and for some, mortgage insurance. For example, the need for homeowners' and mortgage insurance might be identified by the real estate services arm of the supermarket. The concept of buying automobile insurance on a retail store credit card and paying for it in monthly instalments is also beginning to evolve.

It must be noted that the extension of financial conglomerates into general insurance activities may encounter some legal hurdles. So long as insurance products are offered and serviced by individuals who are licensed to do so and the consumer maintains his/her ability to price-shop, it would appear that the activity does not contravene the Insurance Act or the Registered Insurance Brokers' Organization Act respecting unfair business practices and tied selling.

If, however, the premiums for these products are influenced by the number of products the consumer purchases, it may be alleged that coercion or inducements are prevalent that are contrary to the aforementioned Acts. On the other hand, if it can be established that lower premiums are the result of lower costs (and the direct result of synergy which comes from being organized in this fashion) then presumably such marketing does not violate these Acts and, in fact, promotes more innovative delivery systems and mass marketing.

This is a subject on which it is difficult to generalize. Every "financial sources" supermarket may be different, and an assessment of the legalities of their individual activities is well beyond the scope of the Task Force's mandate. It is sufficient to note that financial services conglomerates have the potential to capture a very significant share of the personal lines insurance markets in Canada, and particularly in large urban centres like Toronto. Moreover, for consumers of general insurance products in Canada and Ontario, the opportunity would appear to exist to realize significant benefits from the combination of innovative products and methods of distribution so long as they are not unknowingly shortchanged by the quality of the product and associated customer service. For many of the participants in the general insurance industry in Canada and Ontario, such developments could also be a double-edged sword. Those who are unaligned with such a "full services" conglomerate could find themselves significantly disadvantaged in a marketplace that becomes increasingly "oligarchic" and less truly competitive.

The Problem of Accessibility

As the foregoing description indicates, independent agents and brokers are highly dependent on their relationships with a variety of insurers to ensure access to a sufficient range of insurance products by their clients/consumers. Unfortunately, in a hard market insurers are generally more inclined to terminate what might be perceived as unprofitable relationships with certain brokers and agents. The broker then suffers because he/she is left scrambling to replace the coverage for the insured; the consumer suffers because, among other things, he/she may be classified differently by a new insurer; and the insurer suffers because of the additional costs of terminating the business and (sometimes) replacing it again. This unsatisfactory situation is further

exacerbated by the current severe problems in the liability insurance market highlighted in Part B above, whereby certain specialized risks are underwritten by very few insurers.

These are examples of what can occur in a truly competitive marketplace, and one has difficulty in perceiving how the public is well served under such conditions. It is not known how widespread or prevalent this trend is (or has been in the past), but if the industry is unable to reach agreement in its own ranks with respect to a code of conduct or an agency writer/broker agreement that sees the consumer held "harmless", it may seem reasonable to expect that government or regulators will intervene.

In this connection, the Task Force notes that it does not appear feasible to establish a uniform contract form in Ontario due to the disparity in size of brokers and variations in the types of insurance written. Nevertheless, the Insurance Brokers Association of Ontario (IBAO) has issued "proposed guidelines" for broker/insurer contracts setting out the criteria for such contracts. These guidelines include the following recommendations:

- (1) The contract should be for a fixed term, preferably two years, and should contain an automatic renewal clause renewing the contract on the same terms, unless notice of non-renewal is given 90 days in advance of the expiry date.
- (2) The contract should contain a provision stating that the insurer will not cancel or refuse to renew the contract for the sole reason that the loss ratio of the broker is unsatisfactory.
- (3) The contract should contain a provision stating that in the event of cancellation of the contract by either party the insurer will:
 - (a) provide for a limited brokerage agreement, following the termination of the contract; and
 - (b) permit the broker to determine whether existing policies should be reinsured, replaced or continued in force, according to the terms and conditions of the limited brokerage agreement.

The IBAO efforts to self-regulate the broker/insurer relationship are certainly to be commended. But the Task Force is concerned that such efforts may not be sufficient to protect the consumer interest in access to affordable and adequate insurance. The Task Force therefore recommends that:

- C.14 The Superintendent of Insurance should monitor the situation closely and work with the Insurance Bureau of Canada, the Insurance Brokers Association of Ontario, and other relevant industry associations to ensure the development, application and enforcement of adequate guidelines to govern the broker/insurer relationship, including the orderly transfer of business from terminated agencies.
- C.15 All independent brokers and captive or exclusive agents should be required to disclose to the public the extent of their capacity to sell various types of insurance products and the products of a variety of insurers.

A further means of addressing the problem of accessibility is to encourage networking among brokers. In a number of individual cases studied by the Task Force, it was found that the brokers concerned did not have access to markets that could provide the necessary insurance coverage for their clients. The brokers portrayed the situation as one where insurance was unavailable, when in fact only the knowledge of its availability was inaccessible to the broker. In recent months, it has become all too obvious that the Ontario Liability Insurers pool has become a surrogate for such a network. Agents and brokers with no access to specialized lines of liability insurance such as for day care centres and taverns have flooded the pool with applications.

The Insurance Act of Ontario certainly contains no barriers to either formal or informal networking by brokers. The Task Force understands, however, that insurers prefer to write business that originates in the office of the broker under contract. In the interest of providing an expanded market for brokers to better serve their clients, the Task Force recommends that:

- C.16 The Superintendent of Insurance should actively encourage the insurance industry to permit and facilitate networking procedures among brokers, provided that the originating intermediaries provide much more accurate underwriting information to those in the network, and that the network be set up in such a way that insurers be approached only once with each submission. Disclosure of networking activities should be part of the procedures to protect against possible abuse of networking activities.

More Effective Communications

Another key deficiency in the distribution network identified by the Task Force is the inadequate communication link between insureds and their broker/agents, and between the broker/agents and insurers. In conducting several in-depth case studies of instances where insurance coverage was either unavailable or difficult to obtain, the Task Force discovered that in many cases the broker was unable to precisely understand both the nature of the risk requiring coverage, and the needs of the insured. This in turn means that the broker/agent was unable to provide the insurer with adequate underwriting information, leading frequently to perhaps ill-considered refusals to underwrite the risk. In this connection, the Task Force is well aware that the quality of the broker/agent applications to the Ontario Liability Insurers' pool were more often than not of less than acceptable quality.

Historically, the educational facilities of the industry have largely concentrated on the needs of company personnel. In later years the Insurance Brokers Association of Ontario has maintained a full-time educational department that concentrates on the needs of brokers and their employees. The Insurance Institute recently introduced a series of courses aimed at intermediaries, stressing consumer requirements and giving insight into market knowledge.

Education along these lines is to be commended, and it is hoped that a greater number of both brokers and direct writers will be encouraged to take advantage of these Institute courses and similar courses offered by the Canadian Federation of Insurance Agents and Brokers Associations.

But there is a clear need for greater expertise on the part of intermediaries, particularly given the introduction of new and very complex insurance products such as the claims-made policy discussed in Part B above. In addition, insurance brokers must be in a better position to explain to insureds the details, for example, of their homeowner's and tenant's packages; condominium unit owner policies; the special arrangements that could be made for protection against third-party liability claims; and the possibility of purchasing first-party coverage to cover volunteer activities. Finally, brokers/agents should be much more familiar with risk management and loss prevention.

The Task Force therefore recommends that:

C.17 The Government of Ontario should assist the associations of agents and brokers to offer educational and licensing programs that meet the challenges created by the emergence of new and innovative products and services, and that improve the capacity of their members to assess the soundness of the institutions concerning whose products they advise the consumer. This recommendation was also put forward by the Dupré Task Force. The reference to the ability to assess the financial soundness of insurers is particularly critical given the new statutory duties to be imposed on the brokers under the proposed Compensation Fund legislation (Bill 108).

Another issue arising in respect of the communication problems is the evident failure on the part of intermediaries in the distribution system to utilize present technology and seek out new technology. It is estimated, for example, that less than 50% of all brokers have computers at the present time. Only a few insurers have made available either interface facilities or "stand-alone" microcomputer-based agency management systems. While primarily intended to improve internal systems and efficiency, the systems are also meant to enhance broker office efficiency and the ease with which their brokers can deal with the insurers.

The Task Force is aware of the existence of the Centre for Study of Insurance Operations (CSIO). The CSIO was incorporated in 1981, as a non-profit joint venture between the Canadian Federation of Insurance Agents and Brokers Associations and a number of independent agency insurance companies that write about 60% of the total premiums in Canada. Currently, the CSIO is working on five programs with the goal of increasing the effectiveness and efficiency of the independent agent/company delivery system.

The Task Force commends such initiatives and recommends that:

C.18 The insurance industry should be actively encouraged to pursue joint projects, such as those carried out under the aegis of the Centre for Study of Insurance Operations, much more aggressively.

Inadequate Industry Data Bases

The current insurance crunch is unquestionably exacerbated by the inadequate industry data bases, particularly in respect of liability insurance. For example, while automobile insurers routinely file information such as rate manuals and rate evaluations and report loss statistics according to a uniform statistical plan, similar information in respect of other lines of general insurance is not provided. The deficiency of the data bases will be discussed in further detail in Part D in respect of rate regulation.

The Task Force is of course aware of substantial improvements in the data bases to date. For example, the IBC has improved the Commercial Lines Statistical Plan through additional definitions as to the cause of losses and better coding criteria. And a new schedule rating was implemented shortly after 1979, which today is represented in the IAO's Rapidscan service. More recently, a new general liability statistical plan has been developed by the IBC and will be implemented in the near future.

Nevertheless, it is clear to the Task Force that greatly improved industry data bases would facilitate the underwriting of what are now perceived as difficult liability risks. The Task Force therefore recommends that:

- C.19 The Superintendent of Insurance should work closely with the insurance industry, particularly the Insurance Bureau of Canada and Insurers' Advisory Organization, to improve the collection of statistics in respect of non-automobile commercial lines of insurance, and to mandate the collection of specific data and information in a similar way to that currently in place in respect of automobile statistics.
- C.20 Strong consideration should be given to the establishment of a body parallel to the United States Consumer Product Safety Commission, which operates the National Electronic Injury Surveillance system (NEISS). All emergency wards of major U.S. hospitals are plugged into the NEISS system, which feeds in data on product-related injuries. In this way a much more effective statistical base and early warning system with respect to potential areas of product liability can be built up. Similar statistics on occupiers' and professional liability should also be collected and analyzed more systematically and comprehensively.

Commission Rate Structure

Another area of concern with the distribution system is that of the commission rate structure. Critics of the structure argue that it bears no resemblance to pay-for-value-received. The percentage commission rate structure predominates the insurance market in Ontario. Normally, the higher the premium, the higher the commission paid to the broker. There is, however, some variance in commission rates at present. For example, in automobile insurance the commission paid for unmarried males under age 23 is lower than for other risks, because of the size of the premiums involved.

On the whole, it seems clear to the Task Force that the present commission structure does not adequately reflect the equation between work done and value received by the insureds. For example, the amount of work involved with the initial application for insurance and the issuance of the policy is normally significantly greater than that which is associated with a renewal in a subsequent year.

Certainly, it would appear that there is scope to change the present system of percentage commissions. Such change should be explored, developed and implemented jointly by the insurers and the brokers. One possibility is a fee for service system (to both insurers and insureds) or flat-rate commissions from insurers to brokers with add-ons payable by insureds to brokers for additional services. Such a system would need to include disincentives to prevent insurers from failing to renew the same level of risk and to prevent brokers from indiscriminately moving their book of business and thereby expanding the opportunity for additional services. In the end, the overall cost to consumers might be the same but it could be redistributed in fairer proportion to their needs. And consumers could assess their needs in relation to cost much more accurately.

The Task Force therefore recommends that:

- C.21 Insurers and brokers should consider the establishment of a sliding scale for commissions based on class and premium. Such a scale should take into account the amount of servicing required. The changes should be implemented by July 1, 1987, at the latest.
- C.22 With respect to large risks, strong consideration should be given to a "fee-for-service" as an alternative to or in combination with the present commission rate structure, bearing in mind that the acquisition costs to the intermediary, as well as the servicing, risk management and loss prevention costs are relatively high.

- C.23 All independent brokers and captive or exclusive agents should make available to customers upon request the commission schedules that apply to the various lines of property and casualty insurance which they handle.

Providing Capacity and Availability in all Areas of the Province

It would be appropriate to conclude this discussion of the distribution system with a mention of the difficulties encountered in obtaining insurance in remote areas of the province, particularly in Northern Ontario. This subject has been addressed on a number of occasions, notably in the 1979 Select Committee Report in which it was suggested that all insurers be required, as a condition of their licence, to write in all areas of the province and to apply the "take-all-comers" principle.

- C.24 The Government of Ontario should strongly consider the establishment of a government-sponsored residual market mechanism to ensure the availability of adequate, affordable insurance in all parts of the province. Consideration should also be given to the establishment, in conjunction with the insurance industry, of a toll-free province-wide enquiry and placement service.

IV TRANSACTIONS COSTS

It cannot be doubted that the operations of the insurance industry entail very high transactions costs. While there is no strict consensus on the matter, most people believe that the transactions costs are excessive in relation to the level and quality of service provided.

Transactions costs comprise a number of components. First, there are the costs of selling insurance contracts by insurers, which involve brokers' and agents' commissions, direct selling costs, and the costs of organizing and operating a sales network. Second, there are the costs of administration, and those associated with monitoring and servicing the insurance contracts. Third, there are the claims settlement costs, including legal and adjusting costs. Finally, there are the different costs associated with meeting regulatory requirements, premium taxes, and with administering the investment portfolio.

As the accompanying pie charts indicate, the transaction costs are by no means a trivial proportion of the premium dollar. By far the largest and most troublesome and unpredictable component is that of claims and adjustment expenses (including legal expenses) which amount to 57.6% in personal property lines, 53.6% in commercial property lines, 71.4% in automobile lines, and 57.9% in general liability lines.

In 1979, the Select Committee took issue with the insurance industry's disclosure practices with respect to legal and adjusting costs. It was pointed out that by charging such costs to the claims file and showing them as simply part of the amounts returned to claimants as claims paid, insurers were able to avoid the public scrutiny that such costs merited, and were prone to abuse them. Recommendations were therefore put forward to force such disclosure.

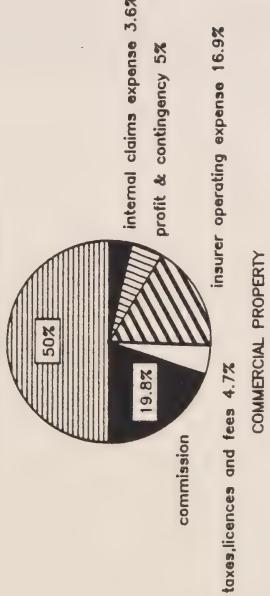
Unfortunately, the extent of public disclosure of legal and adjusting costs has not changed since the Select Committee Report. As noted above, particularly in connection with costs of the tort component of bodily injury claims, the absence of such disclosure has greatly hampered the Task Force in its efforts to assess such things as the relative impact of court awards and settlements on the system and the costs of the distribution system.

At the moment, legal and adjusting costs are not segregated, and are disclosed as an overall amount by both federally and provincially incorporated insurance companies to the respective regulatory authorities. Only portions of these filings for each company are available to the public.

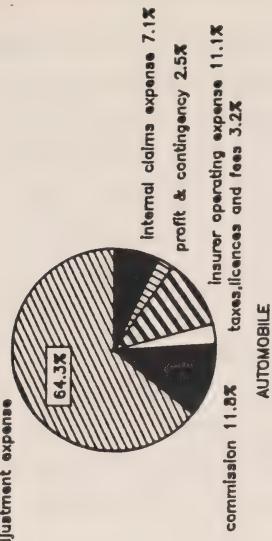
The IBC summarizes data voluntarily submitted by the companies in Ontario that write approximately 80% of all direct premiums. The category of external claims expense does not, however, distinguish between legal fees, adjuster fees, appraiser fees, expert fees, and other external costs. More importantly, even these data are not generally available to the public.

COMPONENTS OF PROPERTY/CASUALTY PREMIUM DOLLAR

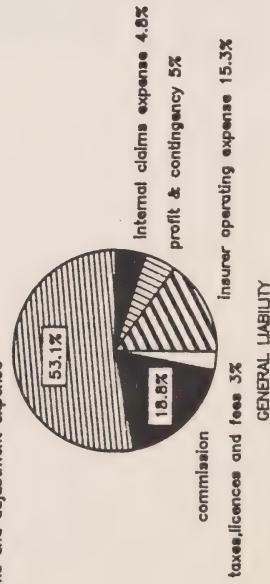
claims and adjustment expense



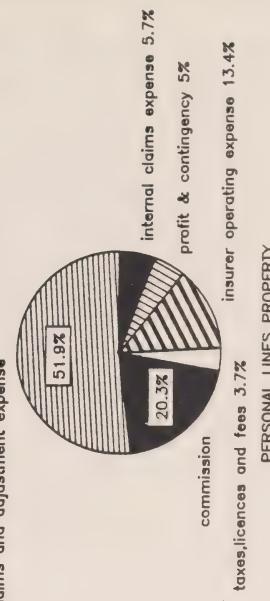
claims and adjustment expense



claims and adjustment expense



claims and adjustment expense



Source:

- Analysis of IBC 1984 Expense Allocation Program Results - Exhibit 1

The Task Force, as discussed earlier in a number of sections, finds the absence of empirical data on and analysis of the property and casualty industry to be lamentable, particularly in the liability insurance area. In this connection, it is clearly in the interest of the other users such as the professions, exporters to the United States, municipalities, and all users who have been adversely affected by the insurance crisis to have accurate data of their experience. Insurers must also have this to set price. In particular, components of transactions costs, and segregated legal and adjustment expenses must be identified. The Task Force is also convinced that more meaningful statistics and empirical data are vital to the cost-effectiveness of the insurance system and will permit, for example, much more effective analysis of the factors contributing to increases in claim payments, and a more accurate record of the specific Canadian experience for the purposes of reinsurance.

The Task Force therefore recommends that:

- C.25 The Superintendent of Insurance should be directed to work with the Canadian Council of Superintendents to implement the necessary modification to the statutory financial statements to require disclosure, for publication, of segregated legal and adjustment costs, as well as the net percentage of premium dollars returned to claimants in the form of claims benefits for the immediately preceding year.

P A R T D

T H E R O L E
O F
G O V E R N M E N T

PART D

THE ROLE OF GOVERNMENT

I INTRODUCTION

The insurance industry has generally involved private entities including joint stock companies, and various forms of mutuals, co-operatives and pools.

The property and casualty insurance industry has long been subject to government interest. The government establishes the regulatory framework within which insurance companies must operate.¹ This extends to the regulation of the insurance contract itself, the market behaviour of participants, and the provision of service and information to the public. It also involves financial regulation relating to solvency matters and other critical financial factors.

Government may also choose to become directly involved in insurance activities through government insurance corporations or, less directly, through facilitating special pool arrangements.

Government concern with property and casualty insurance has greatly increased in recent decades. First, there has been increased concern to ensure that individuals and groups carry sufficient insurance to protect third parties from injury. This has culminated in quite extensive mandatory insurance legislation in respect of a wide range of activities, from day nurseries to professional practice to toxic waste disposal. A list of such legislation in Ontario and Canada is set out in Appendix 6.

Second, government itself, whether federal, provincial or municipal, has expanded its role as a major producer and distributor of goods and services to the public. Government provides roads and airports, municipal services, educational services, recreational and health services, urban and suburban transportation. All these activities generate risks that are a complex mixture of governmental and private responsibility.

¹ See Cassels, Brock & Blackwell, "Ontario and Canada: Overview of Regulation of Insurance" (April 1986) in Appendix 9.

The foregoing simply sets out a brief sketch of the extent of direct and indirect government involvement in the property and casualty insurance industry. This Part will elaborate on such involvement. First, the fundamental bases for government interest will be set out. The subsequent discussion will then focus on the nature of financial and market regulation and proposals for change. Reference will also be made to the impact of government on the property and casualty insurance industry through the taxation system. Finally, the Part concludes with a consideration of governments as more active participants in insurance activities, including the possible role of governmental insurance corporations in Ontario.

II FUNDAMENTAL BASES OF GOVERNMENT INTEREST AND INVOLVEMENT IN THE PROPERTY AND CASUALTY INSURANCE INDUSTRY

In discussing the role of government, actual or potential, in the general insurance industry, it is critical first to identify the "public interest"¹ involved in order to provide some guidance for government action. The nature of this public interest has certainly been the subject of much debate in recent months as escalating demands have been placed on government to do something to correct what are perceived to be market pressures out of control. Increases in automobile insurance premiums have hit thousands of Ontarians in their pocketbooks. But even more importantly, the impact of the crunch on liability insurance coverage for all insureds, from manufacturers and municipalities to day care centres and sports and recreational groups has resulted in cries of "foul play" from almost every niche of the social economy.

The current crisis has highlighted how essential adequate insurance coverage is to the ordinary Canadian, and the pressing public interest in both a stable risk environment and a stable insurance product. The need for a government presence in regulating and supervising the provision and availability of the insurance product has long been accepted. Insurance, defined as the

1 The concept of "public interest" is a difficult one. As pointed out in a paper prepared for the Task Force: "It appears that the 'public interest' as a concept does not have any clear substantive content; it can more usefully be understood as a characterization of the debate about the definition and weighing of various interests. It implies achieving a just balance among all the relevant interests, and a policy consistent with generally accepted principles fundamental to our economic, political, legal, and administrative systems -- principles such as efficiency, accountability, fairness and practicality." See Carolyn Tuohy and Marsha Chandler, "The Role of Government in the Insurance Arena in Ontario: A Political Analysis" (April 1986).

transfer of risk of loss from individuals and organizations to a risk-sharing pool, is quite simply indispensable to modern life. It satisfies pressing needs, both social and individual, for protection. The loss of a home or business premise could be a devastating event in the absence of insurance, and major new investments might not be made without the capability of insuring risks. Certainly, a reduction in risk taking would have far-reaching social and economic consequences in terms of our standards of living, as well as significant individual consequences.

Surprising as it may seem, the general public is only now waking up to the fact that the insurance industry is an essential multi-billion-dollar-a-year component of the financial services industry, and our economic infrastructure, as well as a critical element in our social and economic lives. Most do not realize that, for example, the consumer ought to be as concerned if not more concerned with the possibility that his insurance company might fail, than that his bank might fail. If his bank fails, he may (or may not, given the Canadian Commercial Bank precedent) lose a portion of his deposit. But if his insurance company fails and he suffers a loss, he stands to lose his house, personal belongings or everything, as the recent experiences with the insolvencies of five insurance companies came close to demonstrating. And in a slightly different context, the impact of the failure of the United Canada Insurance Company on the livelihood of its trucker clients further illustrates the essential role played by insurance companies in our day-to-day lives.

The general insurance industry is one in which there has clearly evolved a mix of state/government and market mechanisms. But this mix cannot be explained simply in terms of the "market failure" concept -- that is, that government involvement and interest are triggered only when the private industry is unable to fulfill some essential function. Certainly, market failure may be one basis for government involvement, but other even more important bases include the need to facilitate the pooling of risk and uncertainty, the need to take active measures to reduce the probability of loss, the need to promote the stable functioning of the insurance industry, and the need to address certain redistributive concerns in respect of general insurance activities. It would be useful to discuss each of these bases briefly.

First, the best example of the government interest and involvement on the basis of "market failure" is perhaps the creation of the "Spills Bill" pool and the arrangement with the Ministry of the Environment whereby the government has become effectively the reinsurer of last resort. When it became evident that

the private insurance market was unable to provide the necessary pollution and environmental coverage, the government simply had to step in -- first, to facilitate the formation of the "Spills Bill" pool for certain limited coverage and then, as the reinsurer for the excess through the Ministry of the Environment. Such action was clearly dictated by the public interest in ensuring protection against the eventuality of a catastrophic environmental pollution event.

The second basis for a government interest in general insurance is that of facilitating the pooling of risk, which essentially involves promoting one of the fundamental purposes of insurance -- i.e., to allow individuals in society to reduce the uncertainty associated with possible future losses arising from an ever-expanding range of risks. In this connection, it is clear that exposure to risk in today's complex social economy is inevitable and unavoidable, and we must constantly seek new ways to cope with risk. The risk environment is in a constant state of mutation, due to changes in social and living patterns as well as continual economic and technological change and expansion. Our more densely populated centres and increasingly more complex and sophisticated technologies, products and services all contribute to a much greater opportunity for a higher frequency and magnitude of loss. At the same time, rising property values, increasing liability costs and greater financial risks are reducing the ability of individuals and organizations to cope with the potential size of their own losses. Finally, all this is exacerbated by price inflation, economic uncertainty, heightened consumer consciousness, and increased expectations leading to so-called "social inflation".

In identifying the specific objectives pursued by government in facilitating the pooling of risk, the 1979 Select Committee perhaps put it most succinctly as follows:

- (1) Insurance must be made available to all who want it and need it.
- (2) The insurance product should be of high quality and reliable. For example, contract provisions should be clear and fair; arbitrary cancellations should be prohibited; and consumers should be protected against insurer insolvencies.
- (3) Insurance prices should be as low as possible, not subject to large and sudden changes, and fair among policyholders.

The difficulty in promoting such objectives as availability, affordability and adequacy of insurance is, of course, closely related to the intangible nature of the insurance product itself. As the Select Committee pointed out, the purchase of an insurance contract is a promise of protection and future compensation, rather than an exchange for immediately tangible goods or services. In effect, the policyholder buys the future settlement of a claim, but the consumer in most cases is unable to evaluate an insurer's promises of future performance at the time of purchase. In particular, the consumer is unable to evaluate the financial position of the insurance company as an indication of the ability of the company to pay the future claim. Obviously, the consumer needs information and advice with respect to the coverages and insurance carriers competing for his premium dollar in order to properly evaluate such an intangible product. Indeed the price determination process for insurance is so different from most other products -- inasmuch as the price of insurance is based on future costs which must be predicted, and not on actual costs of production, which are the basic determinants of price for most goods and services -- that the consumer simply cannot alone judge the fairness or reasonableness of the cost.

The existence of the Office of the Superintendent of Insurance (until recently under the auspices of the Ministry of Consumer and Commercial Relations, and now under the new Ministry of Financial Institutions), together with the supervisory and regulatory powers accorded to the Superintendent of Insurance, is perhaps the most obvious example of government involvement to ensure the availability, affordability and adequacy of insurance. As will be noted in the next section, direct regulation has hitherto focused primarily on financial matters related to the solvency of insurance companies, as opposed to the regulation of the insurance market itself. The insurance industry has been subject to reasonably little interference in terms of the type and delivery of the insurance product. In light of recent difficulties during the current crisis, however, it is clear that substantial changes in the regulatory or supervisory roles are now warranted.

A **third** basis for government involvement and interest in the general insurance industry identified above is that of ensuring that active measures to reduce the probability of loss are taken. It is by now well accepted that the government has a legitimate and important role in helping society cope with the risk environment through government participation in a wide range of public safety and loss prevention activities. These include police and fire protection

systems, fire and building code standards, governmental control over hazardous substances, zoning by-laws that prohibit an accumulation of hazards, and governmental participation in other public safety mechanisms, such as inspections.

In future it would be sensible for the government to take the lead in encouraging a debate over the appropriate balance of responsibility for loss prevention and risk management programs, among individuals and groups, insurance companies and public bodies. In addition, consideration might be given to the promotion of more research and development into product and safety standards, more training of personnel in loss prevention and control, and more public education. Finally, the government will need to ensure more accurate and extensive data collection on the causes and extent of losses of all types.

A **fourth** basis for government interest and involvement is in the promotion of the stable functioning of the insurance industry. The justification for such involvement, at least with respect to financial regulation, has been demonstrated most dramatically with the recent insolvencies of no less than five insurance companies. But in addition, the current liability insurance crisis and the lack of availability, or severe problems of affordability in respect of essential insurance coverage, further justifies more government involvement in what may be termed "market regulation".

Proposals for changes in the role of government in financial regulation and market regulation will be discussed further in subsequent sections. Reference has already been made to the need for the government to promote and facilitate a variety of mechanisms to overcome the capacity and availability crunch, particularly in respect of liability insurance.

The **final** basis mentioned above for governmental involvement in the general insurance industry is for the purpose of addressing certain redistributive concerns. Redistributive concerns enter the insurance arena when day care centres, municipalities, hospitals and other collective-good-rendering organizations are put under pressure by high premiums. Inevitably, irresistible pressures are placed on government for relief (by means of public subsidies of premiums, government insurance and so forth), something which is all too evident today. To date, the government has responded to such pressures with the creation of a Market Assistance Program and Hot-Line service, and by

facilitating the creation of the Ontario Liability Insurers (OLI) pool. A number of proposals to relieve these pressures have been put forward in this report based on the assumption that the public interest would be best served if the government uses a variety of instruments to assist, rather than supplant, the private industry in adjusting to the fundamental structural changes that have occurred in the risk environment.

Having now summarized the key bases for government interest and involvement in the general insurance industry, the subsequent discussion will focus on proposals for enhanced financial and market regulation by insurance supervisory authorities. The tax implications of various strategies will also be raised. The final section will describe and assess the various forms of government participation in insurance activities.

III FINANCIAL REGULATION

Types of Regulation

Government presence in the insurance industry has been a fact of life since before Confederation. Regulation has been undertaken through a mix of statutory provisions and administrative rules which can be divided into two broad categories: financial regulation and market regulation.

Financial regulation refers to the controls placed on the structure of insurers, the financial aspects of their operations and their accountability for such operations.

Market regulation refers to the controls placed on the relationship between insurers and insureds and their respective rights and obligations, including contracts of insurance, policies, rates, premiums and insurance delivery networks.

Financial regulation will be dealt with first, and market regulation next.

Under Canada's Constitution, the federal and provincial governments have concurrent jurisdiction over insurance. The federal government regulates the corporate structure and financial standards of federally incorporated

insurance companies, the Canadian branch operations of British and other foreign insurers and provincial companies that have chosen to register federally. Each provincial government regulates the corporate structure and financial standards of provincially incorporated insurance companies, as well as the market operations of all insurance companies (wherever incorporated) which are licenced to do business in that province. The activities of federal and provincial insurance regulatory authorities, therefore, are closely intertwined. The recommendations in this Part, of necessity, address matters within federal and provincial jurisdiction because many companies doing business in Ontario are regulated by both levels of government. For the Task Force to confine its recommendations to matters exclusively within the jurisdiction of Ontario would largely negate its thrust.

Financial Regulation Today

The general philosophy of regulation of financial institutions in Canada during most of the last three decades has been to promote and nurture market competition, a large measure of self-regulation and minimum levels of government regulation. Competition and freedom to expand the range of activities, rather than increases in the regulation of deposit-taking institutions, were the central thrust of the Porter Commission reports and the amendments to the Bank Act which followed them. The application to the trust and loan companies of this thrust admittedly lagged somewhat behind expectations.

The insurance industries -- life, health, property and casualty -- have been highly competitive for decades. Though modernization of their regulation was (and is) needed, it was not needed to promote more competition but for other purposes, some of which will be discussed below.

There are significant structural inhibitions to further competition amongst financial institutions and growth. Different types of financial services have been required, by law, to be conducted through separate corporate vehicles whose objects were limited to a particular type of activity. In addition, these corporate vehicles (primarily banks) are subject to ownership controls which make it difficult, if not impossible, to place the different types of financial services under common ownership for the purpose of integrating such services.

The most recent round of study, therefore, began by focusing on how financial services might be integrated and what law and regulatory reform would be required. Other events, however, soon adjusted the focus of study. The last few years have seen most types of financial institutions (banks, trust and loan companies, securities dealers, property-casualty insurers and credit unions) suffer severe financial difficulty, and sometimes failure. This has led to a new emphasis on financial regulation at both levels of government.

At the moment, the principal emphasis of financial regulation of property and casualty insurers is almost exclusively with solvency issues. This partly reflects the fact that during the last five years, Canada has experienced several insolvencies of general insurance companies, as well as a number of mergers and efforts aimed at strengthening of others, after a long record of solvency. It is clear that some adjustments in statutory and administrative controls are required in order to enable the regulatory authorities to better deal with companies in difficulty.

The emphasis on financial regulation of the general insurance industry also reflects the general concerns with changes in other financial institutions, including: integration of financial services and competition; ownership, self-dealing and conflicts of interest; and solvency generally. Financial regulation of these matters can have major implications for the availability and price of various insurance services and for the cycles of adjustment in the future.

It seems clear that both levels of government will be major players in financial regulation indefinitely into the future, although in the current situation there is once again the tugging and hauling between federal and provincial governments regarding regulatory roles for financial services that have gone on at various periods in this century.

For insurers, it is important to recognize the concurrent jurisdiction of the federal and provincial governments, with the federal presence being preeminent in matters of solvency (through the regulation of federally incorporated insurance companies or branches of foreign insurers) and the provincial governments being preeminent in market behavior (through the regulation of all matters relating to contracts of insurance, including delivery of services, policies and premiums).

The Task Force must recognize nearly a decade of proposals for changes in the regulation of financial institutions, with little action so far. These proposals are mainly found in:

- o the reports of the Ontario Legislature's Select Committee on Company Law in the 1970s, which made a comprehensive set of recommendations for reform of financial and market regulation;
- o the 1982 proposals of the (federal) Superintendent of Insurance for revision of the Canadian and British Insurance Companies Act and the Foreign Insurance Companies Act to increase required capitalization, limit insurance activity in relation to the capital base, regulate more tightly the use of reinsurance, and strengthen regulatory powers;
- o The Regulation of Financial Institutions: Proposals for Discussion, the Minister of Finance's 1985 "Green Paper", and the Technical Supplement thereto;
- o Eleventh Report of the House of Commons Standing Committee on Finance, Trade, and Economic Affairs, presented in late 1985 and known as the "Blenkarn Report";
- o Final Report of the Ontario Task Force on Financial Institutions, released in late 1985 and known as the "Dupre Report";
- o Bill 108 - An Act to Amend the Insurance Act (which received First Reading in the Legislative Assembly of Ontario on February 12, 1986).

Some other items are also marginally relevant to the issues of regulation of general insurance, including the federal and Ontario proposals for amendments to legislation and regulation of trust and loan companies, the reports on financial regulation by the Ontario Securities Commission, the reports and proposals for change in the Canada Deposit Insurance Corporation and the reports and legislation regarding the regulation of the insurance industry in Quebec.

We will consider the issues, the positions of others and the Task Force position on financial regulation of the general insurance activities in Ontario under three broad headings:

(1) Who may carry on business as a general insurer?

- o Initial and Ongoing Capital Requirements
- o Ownership

(2) What financial activities may be carried on by general insurers?

- o Objects
- o Investments
- o Reinsurance
- o Reserves
- o Self-dealing
- o Conflicts of Interest
- o Policyholder Compensation Funds

(3) How are general insurers accountable for their financial activities?

Both federal and provincial proposals for reform will be considered.

Who may carry on business as a general insurer?

Initial and Ongoing Capital Requirements

Any general insurer intending to carry on business either federally or provincially must meet certain statutory minimum unimpaired capital and surplus requirements. For example, a provincial joint stock general insurance company must have unimpaired capital and surplus of at least \$1 million (federally, the figure is \$1.5 million). As a matter of practice, however, regulators have been requiring greater amounts than specified in the statutes for new companies.

Both the Green Paper and the Blenkarn Report propose increases in initial capitalization to \$5 million for federally incorporated general insurance companies. The Dupré Report does not propose any quantitative levels, but favours more rigorous requirements. Ontario Bill 108 proposes initial capitalization for all provincially licensed companies of \$3 million. The definition of capital would also be expanded under the proposals presented in the Green Paper and the Blenkarn Report to include preferred share and subordinated debenture secondary capital in much the same way as that currently allowed to the chartered banks.

In making specific changes, several considerations require attention. First, existing small insurers should be grandfathered, or given time to attain the minimum standard. Second, appropriate reductions in surplus requirements may be allowed for farm mutuals, particularly as they are backed up by a healthy compensation fund. Third, the initial surplus requirements for new mutuals may be somewhat smaller, if they have strong backup solvency conditions. Finally, scope must be permitted for development of reciprocal exchanges. The Task Force therefore recommends that :

- D.1 The statutory initial minimum capitalization requirement should be increased to \$5 million for new federally incorporated property and casualty insurance companies and to \$3 million for Ontario-licensed property and casualty insurance companies.
- D.2 Consideration should be given to the particular situation of existing small insurers, farm mutuals, new mutuals and reciprocal exchanges in implementing the minimum initial capital and surplus requirements.

Insurance companies also are required to maintain assets (including capital and surplus) which are equal to or in excess of their liabilities. In Ontario, the statute contains this simple requirement, while more detailed solvency rules are in the form of in-house guidelines. Federally regulated Canadian general insurance companies are subject to section 103 of the Canadian and British Insurance Companies Act (similar rules apply to British and foreign insurers), which requires a margin of assets over and above liabilities, as well as other solvency rules in the form of in-house guidelines. Essentially, section 103 requires that a company's capital and surplus at least equal the sum of: (i) 15% of the liability for unpaid claims, and (ii) up to 15% of the liability for unearned premiums, depending on the company's past and anticipated claims expense.

Most of the recommendations for future regulation of property and casualty insurance companies propose not only a continuation of the section 103 requirement, but also the addition of other constraining financial ratios. The Blenkarn Report, for example, recommended the addition of a new test, proposed by the federal Department of Insurance, which would require a minimum ongoing capital and surplus margin to be equal to the greatest of: (i) the current section 103 test; (ii) 15% of premiums; and (iii) 22% of claims -- (ii) and (iii) being allowed a maximum reinsurance credit of 50% for companies not limited to the business of reinsurance. In addition, for all of these ratios, conservative rules of valuation of assets (the lower of cost or market) and valuation of liabilities (particularly reserves for claims and reserves for claims incurred but not yet reported) are mandated.

The effect of these provisions is to limit the scale of the activity which insurers can carry on from any particular capital base. The Task Force is convinced that the general intent of intensifying these restrictions is sound. They can help to improve the likely solvency experience of insurers, though other measures are also required to accomplish that intermediate goal. They can contribute also to a reduction of the instability of the industry, though for this objective also, other measures are required. They do not appear to be so severe as to inhibit property and casualty insurers from continuing to be essentially competitive. Combined with increased initial minimum capital and surplus requirements for new entrants, increased ongoing requirements are expected to result in less fragmentation in the property and casualty insurance industry. The Task Force therefore recommends that:

D.3 The appropriate federal and Ontario legislation concerning capital and surplus margins of property and casualty insurers should be amended to provide that the ongoing capital and surplus margins would have to be at least equal to the greatest of:

- (a) the existing requirements of section 103 of the Canadian and British Insurance Companies Act;
- (b) 15% of the gross premium income of the company during the immediately preceding 12-month period plus the smaller of \$500,000 or 5 per cent of the premiums; and
- (c) 22 per cent of the average annual amount of gross claims and claims adjustment expenses incurred by the company during the immediately preceding 36-month period plus the smaller of \$500,000 or 7 per cent of the said average amount;

provided that, in the case of (b) and (c), a maximum reinsurance credit of 50% is allowed for companies not limited to the business of reinsurance.

D.4 Consideration should be given to the particular situation of small insurers, farm mutuals and new mutuals in implementing the minimum continuing capital and surplus requirements.

It is envisaged that property and casualty insurance companies in the future may be the proprietors of downstream subsidiaries, or part of financial holding companies and subsidiaries of other financial institutions or both. The various reports are unanimous in the view that, in considering the capital requirements of these various interrelated institutions, there not be double-counting of capital. The Task Force strongly endorses this view. The Task Force therefore recommends that:

D.5 The initial and ongoing capital requirements recommended above should be applied to each property and casualty insurer without regard to the capital of other corporations with which it may be related or affiliated.

Ownership

The central debate about permitting narrow ownership or requiring broad ownership of financial institutions, and about permitting common ownership of various types of financial institutions (thereby allowing them to be part of conglomerates) is more relevant to deposit-taking institutions (particularly banks and trust and loan companies), than to property and casualty insurers. Some advocates argue that solvency standards of prudent management, quality and reliability of service and the desirable diffusion of power are greatly enhanced by widely diversified ownership. In view, however, of the recent record of troubled financial institutions in Canada, many of which were widely owned, the case is much harder to make than it used to be.

Other advocates suggest that when control and accountability of a financial institution is in the hands of one or a few readily identified owners, more, rather than less, prudent management ensues. Certainly on recent Canadian evidence, this case has to be given some weight.

Self-dealing, fraud and gross mismanagement can and have occurred in recent experience in both narrowly and widely held financial institutions in Canada, and the Task Force sees no reason to favour one form of ownership over another in this regard. While it is correct that the failures of property and casualty insurance companies have been of narrowly owned organizations, narrow ownership is the dominant characteristic in that sector and thus should not be taken as a causal factor in the failures.

Two other ownership questions regarding financial institutions also are high on the public agenda: whether the combination of financial and non-financial corporations in conglomerates should be allowed, and whether foreign ownership should be controlled. Except for the Green Paper, most proposals anticipate a continuation, perhaps some increase, in the inclusion of property and casualty insurance in financial conglomerates. Indeed, many proposals would not only permit such insurers to be under the umbrella of other financial

organizations and financial holding companies, but would also permit some downstream subsidiaries to develop from the base of property and casualty insurance bodies.

There is universal agreement that insurance companies with common ownership must be able to provide reinsurance to each other. The relationship of property and casualty insurers to non-financial institutions within the same corporate group is more controversial. Non-financial bodies have long used the practice of operating captive insurance companies, and under proper conditions this is quite appropriate. General insurance companies are not analogous to deposit-taking institutions which borrow on a leveraged basis. The potential for self-dealing and conflicts of interest between a non-financial institution and a general insurance company, which it may own and control, is significantly less than in the case of deposit-taking institutions.

The property and casualty insurance industry in Canada has long been distinguished by a higher degree of foreign ownership than that of other types of financial institutions. Except for some concerns over the ownership of unregistered reinsurers, a strong sentiment for change does not appear to exist.

The Blenkarn Report is the most useful starting point for considering the ownership issues. It recommends domestic ownership limits for all Canadian-incorporated financial institutions and holding companies controlling affiliated financial institutions based on domestic asset size. Because of their relatively small domestic size (under \$10 billion), existing property and casualty insurance companies would not be subject to these ownership limits on an individual basis. However, companies that are part of holding company structures could be subject to the limits indirectly or directly at the holding company level. Also, holding companies could decide to reduce their ownership interests in property and casualty companies as a means to reduce their aggregated domestic asset size, and hence, meet any ownership limits they might face. Foreign-owned Canadian financial institutions, under the Blenkarn Report proposals, would be subject to similar ownership limits based upon Canadian domestic asset size, but this again would have no impact on property and casualty companies because of their small size. Foreign property and casualty companies would still be allowed to operate through branches in Canada, as they are under current legislation.

The whole area of foreign ownership of financial institutions is under review at the federal level. It remains to be seen whether the limitations on ownership of financial institutions, on a stand-alone basis or in conglomerates, will be as liberal as suggested by the Blenkarn Report. The early indications are to the contrary so there is some uncertainty about the effect on property and casualty insurers.

Given the competitive nature of the industry, with many small insurers as well as some medium and larger ones, and given the need for more capacity, it does not appear to make much sense to restrict severely the ownership of property and casualty insurers. The problems of solvency, instability, and prudent behaviour can be tackled in other ways more effectively. The Task Force therefore recommends that:

- D.6 The federal and provincial governments should retain their current approach to foreign ownership of property and casualty insurance companies.

What financial activities can be carried on by general insurers?

Objects

The statutes under which insurance companies are incorporated generally restrict the objects of such companies to the business of insurance, which is per se a broad area. Companies, however, do specialize because each Canadian jurisdiction has a regime whereby companies are licenced, by the regulatory authorities, for certain classes of business (e.g., property, aviation, surety, boiler and machinery).

The Task Force agrees with maintaining the separate identity and functions of financial institutions, particularly for property and casualty insurers. The Task Force, however, supports reform which would allow "networking" as described in the Green Paper and the Blenkarn Report, i.e., arrangements among financial institutions under which one of the institutions provides the public with access to a product or service offered by any other institution. The Task Force also agrees with the related prohibition on tied sales. The Task Force therefore recommends that:

D.7 Statutory and regulatory roadblocks to networking among the different types of financial institutions should be removed and appropriate statutory prohibitions on tied selling should be implemented.

Investments

The kinds of assets that an insurer may hold are regulated to promote adequate liquidity and stability of asset values over time, and to limit potential losses. The current statutory rules use qualitative criteria to prescribe permissible involvements. Pressure for new rules has come largely from life insurance companies who seek greater flexibility in competing with deposit-taking institutions.

The Task Force supports the general direction for change in the investment rules pertaining to financial institutions as outlined in the Technical Supplement to the Green Paper, which involves a change from qualitative to quantitative measures and, in particular, supports the statutory recognition of the fiduciary duty of such institutions' boards of directors in maintaining prudent investment practices.

The most flexible proposals for new investment rules for property and casualty companies have been proposed by the Blenkarn Report, as follows:

Debt securities and quality mortgages	no limit
Real estate for investment (including subsidiaries)	35% of equity
Real estate for own use (including subsidiaries)	35% of equity
Common stocks	100% of equity
Common stocks of venture capital corporations	10% of equity
Total common stocks, preferred shares and real estate combined	150% of equity
Subsidiaries:	
Financial	no limit
Non-Financial	5% aggregate of assets with maximum of 2% assets in each individual subsidiary
Basket Clause	15% of assets

The view of the Insurance Bureau of Canada that the current rules should not be changed for property-casualty insurers is noted. The IBC has suggested that the portfolio approach might result in a greater number of inappropriate investments, which in time, might contribute to deficiencies in the assets of insurers. In the Task Force's view, there is nothing inherent in a quantitative or portfolio approach that would encourage such a result and that, on balance, the portfolio approach is preferable because of its flexibility. The Task Force therefore recommends that:

- D.8 The investment provisions of the legislation governing federally-regulated companies and Ontario-incorporated companies should be amended to incorporate prudent management standards and the detailed quantitative, not qualitative limits, proposed in the Blenkarn Report.**

Reinsurance

It has been indicated at several points in this report that spreading risks from primary insurers to reinsurers is a central feature of insurance management. Some parts of this network involve associated companies and there is no good reason to disturb the use of such channels. Consideration must be given, however, to two aspects of the use of reinsurance by Canadian insurers.

Some Canadian companies retain very little, if any, of the risk associated with the contracts of insurance that they write. A variety of reasons explain this outcome. In some cases, a company may only be able to provide a market for certain types of insurance (e.g., ocean marine or professional liability) if it can spread the risk widely through reinsurers. In other cases, Canadian-registered companies may simply be used as a conduit for business for companies that are not registered in Canada, with resulting regulatory problems. There is a strong case to be made for reducing the ability of primary insurers to act simply as fronting companies through the introduction of retention limits, while respecting the operation of those companies that provide specialized liability markets.

The Task Force has considered the various proposals with respect to minimum levels of retention of gross premiums written. It notes that the Insurance Bureau of Canada has suggested retention limits as high as 50%, which, in the Task Force's view, would put some companies providing valuable specialty liability markets in a difficult position. The Task Force therefore recommends that:

- D.9 Each primary insurer, where appropriate, should be required, by statute or by regulation, to retain a minimum percentage of its total gross premiums written, such percentage to increase in prescribed amounts of an annual basis over a specified number of years until it reaches at least twenty-five per cent of such premiums.

The Task Force expects that the regulatory authorities will continue to monitor the use of reinsurance in the industry generally and will increase the retention limit when necessary and feasible, having regard to the various circumstances in that insurers conduct business.

The second aspect is the degree of reinsurance written by reinsurers that are not registered to do business in Canada (and thereby are outside the reach of the Canadian regulatory system). Many unregistered reinsurers are stable and secure companies to which Canadian primary insurers should continue to have access. Some unregistered reinsurers, however, give cause for concern in both their operations and solvency.

Two proposals have been made to regulate unregistered reinsurance. The Green Paper proposed that property and casualty insurance companies be prohibited from placing more than 50% of their reinsurance with reinsurance companies not authorized to do business in Canada. The Blenkarn Report recommended that the amount of premiums that a property and casualty company, other than a reinsurance company, could cede to a non-registered insurer should be limited to the amount of premiums ceded to a registered company. In the Task Force's view, neither of these recommendations focuses on the critical element, which is the security that a reinsurer has in Canada for the purpose of backing up its obligations to Canadian primary insurers.

Registered reinsurers will have certain security available in Canada in order to meet the requirement of federal registration or provincial licencing. Unregistered reinsurers may or may not have security in Canada, depending upon their methods of operation.

The Task Force is of the view that more consideration must be given to ways of either requiring or encouraging unregistered reinsurers that do business with Canadian primary insurers to put in place in Canada adequate security to meet their obligations to Canadian primary insurers. The Task Force is not prepared to recommend that the regulatory authorities implement either of the Green Paper or Blenkarn Report proposals at this time. The Task Force therefore recommends that:

- D.10 The federal and Ontario Superintendents of Insurance should give early priority to a reconsideration of the statutory and administrative rules or guidelines governing reinsurance provided by non-registered reinsurers with a view to increasing the degree of security maintained by non-registered reinsurance in Canada in respect of their obligations to Canadian primary insurers.

The Task Force recognizes that, in implementing the minimum continuing capital and surplus requirements recommended in D.3 above, primary insurers will be allowed a reinsurance credit limited to 50%. This may seem to contradict the 25% retention rule recommended in D.9. Supervisory authorities, who monitor the use of reinsurance closely, will be in a position to recommend increases in either the retention level or the credit depending upon improvements in strength of the reinsurance provided to Canadian primary insurers.

Reserves

One of the most important requirements of a responsible, stable general insurance industry is the calculation of, provision for and certification of reserves against claims incurred but not reported, and other contingencies.

The Task Force commissioned a paper on this subject by The Wyatt Company, and endorses its proposal for the more systematic development and application of agreed actuarial methods to this activity (see Appendix 8). The Task Force also endorses the proposal that has been made in several studies and briefs (including the 1982 proposals of the federal Superintendent of Insurance, the Technical Supplement to the Green Paper and the Blenkarn Report) that property and casualty insurance companies submit reports by an actuary or other qualified person to certify that provision made for unpaid claims represents a fair and reasonable estimate of the amount that will be required to settle the claims. Such a step has already been successfully taken in Quebec.

A similar report should be required with respect to the adequacy of a company's unearned premiums to cover claims that may be reasonably expected to occur during the unexpired period of the policies in force. A transition period may have to be given by the regulatory authorities, allowing companies to appoint a person other than a fully qualified actuary if the services of a fully qualified actuary are not available. This will have the benefit of forcing an explicit recognition of the "premium deficiency" item on insurers' balance

sheets, something which is already implicitly recognized in their internal rating and planning procedures. In addition, this should encourage the establishment of insurer stabilization reserves that could serve to moderate the huge premium surges that have been witnessed to date. In fact, there is a very limited number of qualified property and casualty actuaries, and it will take some time for a sufficient number to become qualified. The Task Force urges that the appropriate educational and professional bodies take immediate steps to attract and train such actuaries. The Task Force therefore recommends that:

D.11 Property and casualty insurance companies should be required as soon as possible, subject to appropriate transitional provisions, to appoint a valuation actuary and to include with their annual statement and financial statements a report by the actuary certifying that the provisions for unearned premiums and unpaid claims are adequate.

Further consideration should be given to authorizing the Superintendents to request the filing of loss development triangle analyses from some or all companies in order to allow the Superintendents to monitor reserving practices and the development of reserves.

Self-Dealing

Self-dealing refers to non-arm's-length transactions between a financial institution and its affiliated institutions or controlling interests. As a general proposition regarding regulation of financial institutions, self-dealing has been a factor in a large proportion of the insolvencies, bankruptcies and other extreme difficulties of financial institutions other than property and casualty insurers. Banning it or controlling it strictly, along with requiring thorough disclosure, is strongly supported in every set of proposals. The Dupré Report advocated a prohibition on all non-arm's-length transactions unless true market value of the investment can be objectively ascertained by independent means. It recommended that consent be obtained from the Superintendent of Insurance for insurance transactions which involve self-dealing, it having to be demonstrated that the transaction is in the best interests of the corporation. Moreover, it recommended that every exemption made by consent would require disclosure by the Superintendent to a standing committee of the Legislature.

The Green Paper proposed an outright ban on all non-arm's-length transactions between a financial institution and its affiliated institutions or

controlling interests. A modest purchase or sale of service in the order of 1% of total expenses or revenues and relatively modest loans to officers and directors would be exempted from this ban. Other limited exemptions would also be considered, including special considerations for reinsurance arrangements between affiliated and related insurance companies.

The Blenkarn Report recommended that financial institutions be permitted to engage in non-arm's-length transactions except those that are likely to have a significant impact on an institution's solvency. These prohibited transactions would be set out in regulations governing each of the major sectors of the financial services industry, after consultation with professional associations and representatives from financial institutions. All financial institutions would also be required to establish a committee of the board with responsibility for reviewing and approving these types of transactions. Such a flexible approach to self-dealing could be important to the property and casualty insurance industry because a large number of insurers are members of an affiliated group that uses inter-company reinsurance in order to spread the risk among its membership. A ban on internal reinsurance transactions would force many companies to seek reinsurance in world markets even more than at present, with the result that any difficulties in obtaining it might cause them to limit underwriting, thereby affecting the supply of insurance in Canada. The Task Force therefore recommends that:

- D.12 Property and casualty insurance companies should be permitted to engage in non-arm's-length transactions except those that are likely to have a significant impact on a company's solvency.**
- D.13 The prohibited transactions should be set forth in regulations under the appropriate federal and provincial legislation.**
- D.14 All property and casualty insurers should be required to pass a by-law establishing a committee of the board with responsibility for reviewing and approving all non-arm's-length transactions.**

Conflicts of Interest

Major conflicts of interest appear to be less likely within the general insurance field than, for example, in the trust and loan field, where the roles of trustee and financial intermediary could severely clash. Nevertheless, conflicts will arise among customers or claimants of insurers, or between insureds, brokers and agents and insurers. They can also arise between a general insurance

operation and other operations within a financial conglomerate. A particularly important set of potential conflicts can arise between property and casualty insurers and brokers and agents.

The approach to potential problems should include the creation of "Chinese walls" between fiduciary activities and other operations, increased corporate disclosure and increased public access to remedial action. In a program of regulatory reform, the specific rules and procedures for each sector of the financial services industry would be left to the federal and provincial regulatory authorities. Guidelines for increased disclosure of information would also be developed to enhance the ability of consumers to make informed choices in view of the increased possibility of conflicts of interest resulting from product bundling, corporate affiliations and networking. These aspects of conflicts are especially important for property and casualty insurance. The Task Force therefore recommends that:

D.15 Property and casualty insurance companies should be required to create and maintain "Chinese walls" to prevent the flow of information between certain departments within a company or between affiliated companies where the flow of information might give rise to conflicts between: (i) the interests of customers or claimants of the company; (ii) the interests of a customer and that of the company; or (iii) the interests of a broker or agent and that of the company.

D.16 The federal and provincial regulatory authorities should consult with trade associations, professional groups, insurance companies and consumer groups in developing guidelines for increased institutional disclosure of information to consumers in view of the increased possibility of conflicts of interest arising from product bundling, corporate affiliations and networking.

Policyholder Compensation Funds

The Task Force strongly recommends the mandatory membership of insurers in Compensation Plans as a condition of licencing to carry on business. The Dupré Report favours the development and implementation of industry-operated compensation funds, membership in which would be a condition of licencing in Ontario. The Blenkarn Report recommends that a separate fund be established for general insurance (along with one for life insurance) and that participation in the fund be made mandatory for all federal companies and optional for provincial companies that met the standards set by the fund. The

fund, under Blenkarn's proposals, would be financed by the industry, but would be administered by a national regulatory authority or corporation. Ontario Bill 108 proposes an industry-funded post-assessment fund to operate nationally through a compensation corporation.

The compensation fund proposed in Ontario Bill 108 is quite far-reaching, prompted as it is by the recent insolvencies of The Pitts Insurance Company, Strathcona General Insurance Company, Northern Union Insurance Company Limited, and Northumberland General Insurance Company, and the rehabilitation of Canadian Great Lakes Casualty and Surety Company Limited. A Compensation Corporation would be established, the members of which will include all general insurers licenced by participating jurisdictions. Elected representatives of the industry would sit on the board of directors, while the Superintendents of Insurance would be ex officio members of the board.

The aim of the Fund is to assist claimants in the "personal lines" business rather than to cover typical commercial risks. Therefore, certain types of specialized insurance will be excluded from coverage, such as errors and omissions, and directors' and officers' insurance.

The extent of compensation is limited in the following way:

- o A cap on payment of \$200,000 per claim. (Note that approximately 98% of claims are under this amount and that this is the uninsured motorists' limit.)
- o A deductible of \$500 per claim. (Note that the intention is to hold the broker, not the insured, liable for the deductible, thereby putting the onus on the broker to more thoroughly investigate the financial state of the insurer. The quid pro quo is increased disclosure of financial information as noted above.)
- o Provision that payment be made only after proper determination of the insolvency of an insurer. (Note that the federal government will have to amend the Winding-Up Act to change the priorities of claims and unearned premiums.)
- o A post-assessment system backed by a \$10 million line of credit. This will be based on the total direct premiums related to the covered business a member has written in the jurisdiction where the insolvent company was licenced.

The Task Force notes that the proposed compensation fund legislation also contains additional financial requirements for all property and casualty insurers licenced to do business in Ontario. These include:

- (1) an established ratio of gross written premiums to paid-up capital and surplus, and of net written premiums to paid-up capital and surplus;
- (2) actuarial evaluation as to the adequacy of provisions made for unearned premiums, unpaid claims and claims adjustment expenses;
- (3) limits on amounts that may be permitted to be due from agents of the insurer, in relation to its paid-up capital and surplus, and also from subsidiaries and affiliates of the insurer;
- (4) the necessity of maintaining assets in the form of authorized investments in excess of the outstanding liabilities of the insurer, to be prescribed by regulation; and
- (5) prescribing a maximum portion of risk that may be reinsured with unlicensed insurers, as to each different classification of insurance.

The Task Force commends the foregoing initiatives to establish a compensation fund and to implement related regulatory requirements as important steps in promoting stability in the insurance market. The Task Force, however, questions whether an industry-operated fund is the most desirable model.

The problems faced by a contingency fund operated solely by the industry include the setting and enforcement of standards across all jurisdictions and the need for an adequate fund to protect policyholders against major defaults. Because of variations in standards, monitoring and surveillance across jurisdictions, it will be difficult to set more than minimal standards that would be acceptable to all jurisdictions. Furthermore, early detection and correction of difficulties should be a primary goal of the fund. Either the fund operators themselves or the regulatory authorities on their behalf will have to exercise monitoring, surveillance, and animation of corrective action. Without a fund established by pre-assessment, the industry could face a financial crisis if a major default had to be absorbed over a short period of time, and would probably have to turn to governments for assistance. These were the reasons behind the Blenkarn Report proposals.

If there is no provincial and industry support for federal government initiation with respect to a compensation fund, then the Task Force recommends that Ontario take the initiative and create a fund for property and casualty insurers. A mixed funded and pay-as-you-go basis appears to be the most

appropriate model. Ontario would have to undertake or cause to be undertaken the regulatory activity required for such a fund. The Task Force therefore recommends that:

- D.17 A federal policyholder compensation fund for property and casualty insurers should be established as soon as possible and that membership in such a fund be mandatory for Ontario-licensed property and casualty insurers.
- D.18 If the Government of Ontario determines that a federal fund is not to be formed, the Government should establish a fund for the protection of policyholders in consultation with the industry, and membership in such a fund should be mandatory for Ontario-licensed property and casualty insurers.
- D.19 Any fund established should be funded by both regular assessments to allow accumulation of funds and special assessments based on experience.

It follows from the requirement that all Ontario-licensed property and casualty insurers participate in a compensation fund that the fund itself will be exposed to varying levels of risk depending on the financial strength and stability of each company. The challenge in structuring such a fund is to build in incentives to member insurers to increase their strength and stability. In setting assessment levels, the claim experience of each particular company and the actual cost of supervising and monitoring each company should be considered.

How are the insurers accountable for their financial activities?

Substantial financial information is already collected by the Superintendents of Insurance, largely through the filing of annual statements in the form prescribed by the Superintendents (currently it varies somewhat across jurisdictions) and through examinations. These accountability mechanisms historically have focused on the solvency, financial practices, stability and growth of individual insurers.

It has become apparent that, in some cases, statements should be filed more frequently in order to allow regulatory authorities to monitor the financial position of a company more closely. The federal Superintendent of Insurance made a proposal in 1982 that the appropriate legislation be amended to require any company to file interim financial statements in such detail and with such

frequency as required by the Superintendent. Such statements would have to be filed within 45 days after the closing date of the period to which the statements pertain (90 days in the case of reinsurance). The Task Force agrees that regulatory authorities should have such powers, and recommends that:

- D.20 The appropriate federal and Ontario legislation should be amended to authorize the respective Superintendents of Insurance to require the filing of interim financial statements from such companies, in such form and with such frequency as required by the Superintendent.

Portions of the annual statements of federally regulated companies are currently available to the public. The portions kept confidential are the section 103 solvency test calculation, the investment valuation reserves and the loss development by year.

The Task Force is informed that federal and provincial supervisory officials are developing a new uniform annual statement that will be an enhancement of the federal form and that will require all insurers to adhere to "generally accepted accounting principles". The Task Force therefore recommends that:

- D.21 The federal and provincial regulatory authorities should expedite completion and implementation of the new uniform annual statement, and all parts of such annual statement should be made available to the public in a cost-efficient form.

There have been suggestions that the Superintendents of Insurance should release information on the terms and conditions of companies' licences, as well as information on which companies have been placed on the "watch" list. The Task Force is of the view that the companies and the regulatory authorities involved should be given every opportunity to resolve problems in a private and responsible way. The Task Force emphasizes, however, that better disclosure to the public (both in terms of content and frequency) and the establishment of compensation funds must be put in place in order to ensure that the public is accorded the maximum degree of protection consistent with preventative and rehabilitation efforts by the industry itself or regulatory authorities.

Beyond the questions concerning individual companies and consumers, however, are the problems of obtaining information on a number of critical aspects of the industry's operation, in particular:

- o overall profitability;
- o profitability by lines of insurance and by various geographic regions;
- o elements of operating costs, including selling, claims adjusting, legal and various administrative and transactions costs; and
- o differences in operating costs among various lines of insurance.

Certainly, immediate changes to the nature of financial reports made available to the general public are essential. In this connection, it would be desirable to make use of the permanent federal-provincial consultative mechanism consisting of a council of ministers responsible for financial institutions, as recommended by the Dupre Report, to formulate co-ordinated and uniform reporting and disclosure requirements. The Task Force therefore recommends that:

D.22 A permanent federal-provincial consultative mechanism consisting of a council of ministers responsible for financial institutions should be established and early priority should be given to establishing new industry-wide reporting and disclosure requirements with respect to critical aspects of the industry's operation, in particular:

- o overall profitability;
- o profitability by lines of insurance and by various geographic regions;
- o elements of operating costs, including selling, claims adjusting, legal and various administrative and transactions costs; and
- o differences in operating costs among various lines of insurance.

IV MARKET REGULATION

Introduction

The governmental interest in the availability, reliability and affordability of insurance, as implicit in the Terms of Reference of the Task Force, carries with it an implicit interest in the operations of the insurance marketplace.

The Task Force has explored the operations of the insurance marketplace, with a view to making recommendations in connection with its enhanced performance. The issue remains as to the extent to which government must, or should, be involved in the operation of the marketplace.

The Insurance Contract

The property and casualty insurance industry is basically responsive rather than innovative in the design of insuring agreements. Nevertheless, in recent years, the insurance industry has responded to the changing needs of both corporate and individual consumers by the development of policies to cover such things as strikes, kidnappings, extortion, adverse publicity, takeover attempts or tender offers, tax interruptions and computer crime.

Most consumers already have personal liability protection through their homeowners' policies, and such policies are readily available in Ontario at reasonable cost.

As has been previously noted, the insurance product is an intangible. It is a promise to pay or to respond to an event that might happen in the future. It is embodied in the insurance contract. It is essential that the insuring agreement, as a legal contract, clearly define the rights and obligations of both parties in legal terms that can be reviewed by the court process. This contract may be the most important contract that an insured enters into in his lifetime.

Under the provisions of the Ontario Insurance Act, insurers have the right to develop their own contractual forms, with the exception of the automobile policy forms, and are to be encouraged to develop additional types of insuring agreements designed to meet the needs of their insureds. The existing provisions of section 94 of the Insurance Act should be maintained, thereby giving the Superintendent of Insurance the right to require the filing of any insuring agreement with him and to investigate and report any case where an insurer issues a policy or uses an application that is, in the opinion of the Superintendent, unfair, fraudulent or not in the public interest, to the Minister -- who, if he concurs with the report, may order the Superintendent to prohibit the use of such policy or application. The Task Force therefore recommends:

D.23 The right of insurers to design insuring contracts to meet consumer needs without prior approval should be continued, and that the right of the Superintendent of Insurance and Minister to disallow contracts that are unfair, fraudulent or not in the public interest should be maintained.

Brokers and Agents

The Task Force is aware of the remoteness of the primary insurer from the consumer. To many consumers, the intermediary they deal with is the insurer. This places a heavy responsibility on intermediaries to communicate effectively with both the primary insurer and the consumer. Consumers have indicated the feeling that the primary insurer is unresponsive to their changing needs. Certain intermediaries share this concern.

Some insurers have formed insurer-intermediary committees to consider relationships between themselves and consumers, to strengthen communications, and to allow insurers to become more responsive to their clients. The Task Force therefore recommends that:

- D.24 All primary insurers should establish committees with their brokers that will develop mechanisms responsive to consumers and strengthen communication.**

Small and medium-sized commercial and industrial insureds are, in most cases, not in a position to have their own risk managers. Further, there are programs of risk management that are utilized only for the direct customers of the various insurers, major brokers and associations involved. The Task Force is aware of the expertise that lies within the Ontario Risk and Insurance Management Society with respect to the benefits of risk management services.

There is, however, a lack of direct response to the public in general, a lack of co-ordination in advice and approach, particularly to those purchasers of insurance who have been severely affected in the liability insurance field. It is important that all intermediaries be familiar with the principles of risk management, as well as being aware of the loss prevention services that can be provided. By judicious use of the principles of risk management and loss prevention, insurance costs can be controlled to some extent, and risk exposure reduced and dealt with more effectively. The Task Force therefore recommends that:

- D.26 The Insurance Bureau of Canada and The Insurers' Advisory Organization, together with the Insurance Brokers Association of Ontario, should accept and adopt as their mandate the promotion of risk management services through appropriate arms of the insurance industry, in order that public education of risk management services and loss prevention control can be co-ordinated, promoted, and the public assisted, particularly those insureds facing difficulties with respect to liability insurance coverage.**

Governments have historically assumed responsibility for protecting the public from losses. This includes police and fire protection systems, fire and building code standards, government regulation of hazardous substances, zoning by-laws that prohibit an accumulation of hazards, and government participation in other public safety mechanisms, such as inspections.

Insurance companies take account of the level of fire protection services in a municipality in determining the cost of property insurance coverage. There is arguably no reason why a greater focus on risk management programs, loss control through hazard identification, pre-loss inspections, etc., could not permit similar premium differentiation in respect of all types of liability insurance. The Task Force therefore recommends that:

- D.27 The Government of Ontario, through the Interministerial Committee established to deal with property and casualty insurance problems, should take the lead in encouraging a debate over the appropriate balance of responsibility for such loss prevention measures among individuals or businesses, insurance companies and public bodies. In addition, it should promote more research and development into product and safety standards, more training of personnel in loss prevention and control (see, for example, the IAO's School of Loss Control Technology), and more public education. Finally, the government should require more data collection on the causes and extent of losses of all types.

Superintendent's Role

The Task Force, in making the foregoing recommendations (D.24 to D.30) concerning brokers and agents, is cognizant of the fact that the changes in the distribution system that it has recommended are a fundamental part of the structural changes necessary to deal with the current problems of availability, reliability and affordability of insurance contracts in the province. Without such changes being made, there will not be a clear and demonstrated response by the insurance industry to meet the current essential needs of the consumers endeavouring to utilize the system. The Task Force therefore recommends that:

- D.28 The Superintendent of Insurance should include in his annual report to the Minister a special report with respect to the progress of industry associations towards achieving the necessary structural changes to the system encompassed in the foregoing recommendations.

Advance Notice of Changes

The basic insurance contract is provided through an agent/broker to an insured, generally through an annual contract. The agent/broker assumes responsibility for renewal, and is the main contact with the insured. As recent events have illustrated, changes in price can occur much more frequently than annually, and the startling effect of a substantial price increase occurs at the time the insured receives notification from his agent/broker. In a similar fashion, deletion of coverages, increases in deductibles and the addition of exclusions under an insurance contract add to the pressure placed upon an insured in a short period of time to accept or reject the contract as offered through his agent/broker.

The situation with non-renewal has been demonstrated to be equally severe; in many instances, the agent/broker is left in a position of not knowing whether a renewal of an existing coverage in a very restricted market will be forthcoming.

The Insurance Bureau of Canada issued to its member companies guidelines for handling non-renewals of personal line policies in October 1976. Although similar guidelines might be considered for commercial line policies, there is some suggestion that primary insurers often do not know until very close to the renewal date whether reinsurance will be available. Primary insurers would be at a distinct disadvantage if they had to decide whether or not to extend coverage in advance of a reinsurer's decision.

Problems similar to those in Canada occurred in the United States long before they surfaced here.

As a first step to deal with the lack of insurance coverage many industries were facing, some states passed new regulations with respect to non-renewals and to prevent insurance companies from cancelling policies in midterm without adequate notice. Critics, however, felt that such actions would make insurers more reluctant to write risks in those states, and would cause some to leave states, adding to the lack-of-capacity problem.

Until now this has been a routine marketplace activity that has generally been well handled by both brokers and insurers. Government regulation

in this area, e.g., to force statutory notices of non-renewal, could well exacerbate this system and force insurers to come to premature decisions. Nevertheless, insureds must be kept adequately informed of changes. The Task Force therefore recommends that:

D.29 The insurance brokers (through their association, the Insurance Brokers Association of Ontario) and the insurers (through the Insurance Bureau of Canada), under the aegis of the Superintendent of Insurance, should develop guidelines which will ensure timely notification to insureds of changes in price, coverage, exclusions and non-renewal. This recommendation is made on the basis that marketplace guidelines would be the best solution but on the express understanding that failure to arrive at a solution would result in a mandated standard, in each instance, by government regulation.

Rate Regulation

Regulation of insurance rates in Ontario exists only in the case of the Facility Association (the automobile residual market, which is discussed in Part C). It has been proposed by various interested parties in Ontario as a stabilizing factor. It is inexorably linked to solvency regulation of individual insurers. While it appears that the provinces have authority to legislate with respect to rate regulation, it must be borne in mind that the majority of insurers operating in Ontario are federally regulated with respect to their solvency.

In this area, the Superintendent of Insurance continues to rely principally on moral suasion to resolve problems in the industry, backed by the implied threat that the unproclaimed sections of the Insurance Act extending his authority over unfair and discriminatory rates could be proclaimed if moral suasion fails.

Once again, however, the Superintendent is also hampered in his efforts by the nature of the information he receives. For example, while some major automobile insurers voluntarily file information such as rate manuals and rate evaluations, information on other lines of general insurance is not provided in a similarly consistent fashion. And with respect to loss statistics for various types of general insurance, reporting according to a uniform statistical plan is mandatory in automobile lines, but not in property and casualty lines.

The Task Force is of course aware of substantial improvements in the data bases to date. For example, the IBC has improved the Commercial Lines Statistical Plan through additional definitions as to the cause of losses and better coding criteria. New schedule rating was implemented shortly after 1979 which is today represented in the IAO's Rapidscan service. More recently, a new general liability statistical plan has been developed by the IBC and will be implemented in the near future.

It is also important to understand the role played by the Insurers' Advisory Organization before making any recommendations in respect of rate regulation. The Insurers' Advisory Organization (IAO) is the largest insurance advisory rate-making body in Canada.

The IAO is comprised of over fifty member company groups who write property and casualty insurance in Canada; since April 1985, its services have been available to members on a "user-pay" basis. Prior to that time, its services were only available to members who paid an annual assessment, regardless of the extent to which they used the service. IAO-promulgated rates are "advisory" only and members are under no compulsion to use them. The rates are "advisory" in nature to avoid, among other things, difficulties with the federal Combines Investigation Act. In actual fact, very few companies utilized IAO rates in 1985 for automobile insurance (see Table 1 in the research paper prepared for the Task Force by Woods, Gordon entitled "The Distribution System").

The IAO recommends rates for automobile insurance in Canada in all jurisdictions which are not serviced by public insurers, and for personal and commercial property country-wide. The IAO does not make rates for commercial liability because no credible statistics exist on which to begin the process. The "Red Book" generated by the IBC's statistical reporting service has been generally regarded as less than adequate.

Accordingly, the IAO advisory rate-making service is used by many insurers as the base for automobile and personal and commercial property rates from which they can create their own rates utilizing their own estimated loss experience and operating cost profile. For others, IAO rates are used as a benchmark, for comparative purposes, against which to test their own forecasts about rates. For other specialized classes of insurance or for unusual risks,

insurers create their own rates based upon their own experience, underwriting criteria and operating cost profile.

Assuming the desirability of greater stability of insurance rates, particularly in light of the "yo-yo" pattern of recent years, there are several options available to improve the monitoring of the effectiveness of competition in insurance markets and thereby ensure that the consumer obtains the "best" price and insurance product possible. These include rigid rate regulation, prior approval of rate changes, and open competition rate regulation (no filing required).

There are inherent dangers in establishing a process of rate regulation:

- It may tend to favour the regulated industry. Insurer interests, with their more concentrated stakes, will have greater incentives to mobilize and greater access to relevant information and will disadvantage the less-informed consumer interest. This may result in rates being set too high.
- On the other hand, rates that are set too low can drive capital from the industry. For example, a few concentrated consumer interests might force rates to be held to below normal rates of return, with a resulting shift of capital out of the industry, a decline in capacity, and ensuing shortages in supply.
- While rates of return may be set just right, they can also fail to provide incentives to increase productivity.

Rate regulation has been tried, in its various forms, in the United States with respect to insurance rates. The opinion is that the effects have been largely cosmetic, in that regulators allow deviations from established levels in rates that are, in effect, determined by competitive forces.

In its 1979 report, the Select Committee considered and opted for open competition rate regulation (no filing required) for monitoring the effectiveness of competition. It recommended that the Superintendent require reporting of data that would satisfy the monitoring tests developed in the United States by the National Association of Insurance Commissioners (NAIC) with respect to performance indicators, structural indicators and conduct tests. (Performance indicators include the components mentioned earlier with respect to suggested improvements in financial reporting, together with information on variations in rates and price changes per company per year. Structural indicators include concentration ratios by line, market share ranking by line, and information on

entries and exits. Conduct tests are less precise, but would focus on the relevant practices of the insurer in question, issues of integrity, avoidance of conflicts of interest and so forth.)

The Task Force has concluded that the option of rigid rate regulation is not a desirable direction for government action. Equally, despite the apparent success of such rate boards as the one in Alberta, the evidence is unclear as to whether the presence of a rate board is really a material factor in the increased rate stability in Alberta compared to other jurisdictions.

The Task Force has concluded, however, that the government should strongly consider implementing a systematic framework for the monitoring, surveillance and evaluation of rates. Such regulation does not entail setting floors or ceilings on rates. But insofar as it involves a much more systematic public analysis of the underlying determinants of rates, it would certainly result in much more rate stability than we have witnessed to date. The Task Force therefore recommends that:

D.30 The Government of Ontario should seriously consider the implementation of a systematic framework for the monitoring, surveillance and evaluation of rates with a view to ensuring greater rate stability and public understanding of the determinants of rates and the basis for the rate changes.

In conjunction with the implementation of such a framework, it is also recommended that the Superintendent submit an annual report to the Ontario Legislature that would include a review of the competitive indicators monitored by the Superintendent, and a critical commentary on the analyses related to the statistical information. This too was recommended by the Select Committee in 1979 and would involve amendments to Sections 13 and 90 of the Insurance Act.

The concept has been implemented in Quebec in the form of the annual report of the Inspecteur des Institutions Financières. Although some argue that the comments therein on the propriety of rates come "too little, too late", no one doubts that the annual report is a useful innovation. Most recently the Dupré Report has likewise concluded that the tabling of the Superintendent's report with a standing committee of the Legislature is highly desirable, and would be an important component of any package of reforms aimed at improving the public's confidence in the financial system. The Task Force therefore recommends that:

D.31 The Superintendent of Insurance should be required to file an annual report to the Legislature forthwith after the end of a calendar year but not later than April 30, providing disclosure of the loss and expense data and a review of the competitive indicators monitored by his office.

It should be noted that, in respect of automobile insurance, as noted in Part C, the Task Force does favour greater supervision of the rates established by the Facility Association, particularly as to classification of risks and surcharges.

The Task Force does not recommend the proclamation of sections 369 to 371 of the Insurance Act at this time. These provisions would give the Superintendent very wide powers of regulation which do not appear to be necessary and are not appropriate in the context of the introduction of monitoring, surveillance and evaluation of rates.

V SUPERVISION OF INSURERS

Introduction

As noted above in "Financial Regulation", a number of recent reports have focused attention on the important goal of enacting more rigorous controls on the financial activities of property and casualty insurers (as well as those of other financial institutions). These reports also reflect other principal concerns of both supervisory authorities and insurers, including:

- o supervisory powers with respect to troubled companies;
- o modernization of the corporate governance statutory provisions; and,
- o strengthening of the supervisory system in general.

The Task Force agrees with the over-all need for change in the very near future in order that supervisory authorities will have the proper support and powers to enable them to carry out their duties adequately and that insurers will have the opportunity to function within the checks and balances of modern-day corporate law.

Immediate Needs

Cease and Desist Orders

The Ontario Insurance Act authorizes the Superintendent of Insurance to issue cease and desist orders to prohibit certain unfair and deceptive practices. The Insurance Act does not authorize the Superintendent to issue such orders with respect to corporate practices or with respect to an insurer's financial activities. Further, the Insurance Act does not authorize the Superintendent to issue orders to compel a company to take specific courses of action (other than making good a deficiency of assets). The remedial powers of the Superintendent and the Minister are confined to suspending or revoking a company's license in certain circumstances, or taking control of the assets of a company in certain circumstances. The federal Superintendent's powers are similarly limited under federal legislation.

The federal Superintendent of Insurance has recommended that the federal legislation be amended to give specific authority to the Superintendent to direct a registered insurance company to cease doing any act or pursuing any course of conduct that might reasonably be expected to prejudice or adversely affect the interests of policyholders of the company or to result in the company being in violation of its governing legislation. The federal Superintendent has also recommended that supervisory authorities be authorized to direct a company to take specific courses of action that appear necessary to protect the assets of the company or their value, to ensure that the company carries on its business in a sound, business-like manner, and generally to safeguard the interests of policyholders.

It is essential that the Superintendent be authorized to take action without prior notice to the company in circumstances where the vital interests of policyholders or the public may be prejudiced by the delay involved in a notice procedure. The Task Force agrees that the supervisory authorities should have such powers and the Task Force therefore recommends that:

D.32 The insurance legislation of Canada and Ontario should be amended to authorize the respective Superintendents of Insurance to issue orders requiring a registered or licensed insurance company to:

- a) cease doing any act or pursuing any course of conduct that might reasonably be expected to prejudice or adversely affect the interests of policyholders of the company or to result in the company being in violation of its governing legislation; and,

- b) take specific courses of action that appear necessary to protect the assets of the company or their value, to ensure that the company carries on its business in a sound, business-like manner and generally to safeguard the interests of policyholders,

and that, in particular, the Superintendent be authorized to proceed without prior notice to the company in circumstances where the vital interests of policyholders or the public may be prejudiced by delay.

Role in Administering Companies in Difficulty

There generally is an interregnum between the time when a Superintendent of Insurance takes control of the assets of a company and the time when it is decided whether the company can be rehabilitated or must be wound up. The Superintendent may be placed in a difficult position during this phase.

The Superintendent may be reluctant to maintain "business as usual" until it is known for certain whether the company can be rehabilitated. This may tend to make rehabilitation more difficult and wind-up more likely. Until a compensation fund or funds are established the Superintendents will continue to be placed in a difficult position. The Task Force has already recommended elsewhere in this Report the creation of a compensation fund .

Structures for the Future

Corporate Governance

Both the Green Paper and the Blenkarn Report have made extensive recommendations with respect to the modernization of corporate governance. The Insurance Bureau of Canada agrees on the need to bring insurance legislation into line with modern approaches to corporate law generally and sound business practices for financial institutions in particular. The Task Force therefore recommends that:

- D.33 Federal and provincial authorities should accord immediate priority to revision of insurance legislation to bring it into line with modern approaches to corporate law generally and sound business practices for insurance companies, and resulting legislative amendments should include a provision requiring regular review of the legislation governing insurance companies.

Supervisory System

The Green Paper, Blenkarn Report and Dupré Report all favour a greater centralization of supervision for financial institutions. The Dupré Report recommends that this occur separately at the provincial level, while the Green Paper proposes an amalgamation of the federal regulatory agencies. The Blenkarn Report, taking a broader approach to this issue, recommends the establishment of a National Financial Administration Agency (NFAA) that would include both federal and provincial participation along with private sector participation. This agency would be national in scope and involve both supervisory and policy responsibilities.

Under each of the federal proposals, the regulatory agencies would be responsible for all financial institutions, with a separate branch for, *inter alia*, general insurance companies. The Blenkarn Report and the Dupré Report recommend that all regulatory costs be charged back to the supervised institutions.

The Green Paper and the Dupré Report recommend federal-provincial mechanisms to harmonize policies and implementation, whereas the Blenkarn Report would involve joint federal-, provincial-, and private-sector control of the agency, which would set common standards and assure consistent enforcement. In the Task Force's view, the Blenkarn Report recommendations should be viewed as the ultimate goal for the Canadian regulatory system. The Task Force recognizes, however, that at this point both the federal and provincial governments appear reluctant to transfer their authority and responsibilities (particularly for policy) to such an independent agency.

As a result, it is likely that separate federal and provincial regulatory structures will remain in place with centralization of the agencies occurring in both jurisdictions. Unfortunately, this also removes the prospect of greater self-regulation that was proposed in the NFAA concept since the private sector will not participate, under those proposals, in the operations of the agency.

The Task Force therefore recommends that:

- D.34 The federal, provincial and territorial governments should immediately establish a Council of Ministers Responsible for Financial Institutions to consider in advance all matters pertaining to the policies and regulatory practices governing financial institutions, including property and casualty insurance companies.

VI TAXATION

Introduction

Though taxation affects risk and insurance in many ways, four matters of special interest turned up in the work of the Task Force. The first is the personal income tax on claims paid to individuals, particularly compensation for bodily injury. The second concerns the treatment of reserves held by taxpaying financial and non-financial producers of goods and services which self-insure part or all of the risks to which they are exposed. The third is captive insurance companies. The fourth is the tax treatment of stabilization reserves and reserves against future shock losses by insurers.

The general nature of the tax treatment of premium payments and claims receipts in property and casualty insurance must be understood before considering these tax issues. Citizens as householders, car owners, etc., pay insurance premiums which are not deductible; i.e., they are paid out of after-tax dollars. Claims paid under such policies are not taxable. Similarly, if someone purchases an income replacement policy or a disability income policy, the premiums are not deductible and any payments under the policy are not taxable.

If, as a result of a personal injury, a person recovers, as a third party under someone else's policy, a lump sum payment representing loss of future income, the lump sum is not taxable. Income earned on the lump sum is taxable, as is the interest element of an annuity purchased with the lump sum. If, however, the lump sum is paid out in the form of a structured settlement, none of the monies is taxable.

Claims paid on account of additional costs of care that have arisen from an injury are not income; they are compensation for costs that would not otherwise have been incurred. However, in certain circumstances a part of claims paid to persons under this heading has been subject to personal income tax in Canada -- wrongly, as the Task Force argues below. Claims paid for rehabilitation and miscellaneous special help required by the injury likewise are not income and should not be treated as taxable income; they are usually excluded.

What about compensation for non-economic losses, payments as compensation for pain and suffering of the victim, or payment to family members of a person injured or killed for the loss of care, comfort and companionship? Lump sum payments of such compensation have not been treated as taxable income, though income from the investment of that capital would be taxable in future years.

The tax treatment of the non-personal insured is, with some exceptions discussed below, straight forward and proper. Businesses generally treat premium payments to insurers as expenses in reckoning their taxable income, and this is normally accepted by the tax authorities. If a business suffers a loss and receives compensation from an insurer, the loss is partly or fully offset by the payment from the insurer. The receipt only affects the net capital and surplus position of the insured, and enters into the tax treatment of business income and capital gains in the ordinary way.

Compensation for Future Care Costs

The first of the serious taxation issues which the Task Force confronted was the tax treatment of lump sum claims for the economic losses associated with the costs of future care of injured persons. This is the famous "gross-up" issue. If a lump sum award or settlement is made to meet the costs of future care, the revenue from the lump sum for a number of years after the award will exceed the actual and possibly deductible costs of care. If the actuarial expectations on which the lump sum was calculated, before taxes, are precisely fulfilled, the excess of income in the early years will exactly balance off the deficiency in the later years. The injured will start with no capital and end with no capital. However strange it may seem, under the personal income tax system the excess of revenue over costs of care in the early years is taxed as income. However, in the later years, when the costs of care exceed the revenue from the then diminished capital sum, equivalent amounts are not given back from the consolidated revenue fund.

The Task Force considers this practice to be a fundamentally improper taxation of awards and settlements for the cost of future care. The fundamentals are argued in Appendix 20. The tax authorities acknowledge, though they have not legislated on the matter, that costs for care of an injured

person are compensation for an economic loss, and not income. If the stream of future costs on this account is matched by a structured settlement which provides a matching stream of payments, then no part of such payments is regarded as income for taxation purposes. If a lump sum is paid in lieu of a stream of future revenue to meet these anticipated costs, the injured person under normal actuarial expectations has no net increment of wealth or net increment of income over the life of the settlement. Therefore there is no net income and there should be no net income tax. In fairness, if the tax authorities tax a part of the revenue in the early years, they should furnish refundable, transferrable tax credits which can be exercised in the later years. This would be far too cumbersome and open to abuse. The Task Force therefore recommends that:

D.35 The taxation of revenue from lump sum settlements which arise as compensation for the economic losses of injured persons under the heading of costs of future care should be abolished. This would eliminate gross-up with respect to the cost of future care.

D.36 The practice of exempting structured settlements for compensation for the economic losses of injured persons under the heading of costs of future care should be continued and codified.

Self-Funded Reserves

The second issue concerns the taxation of self-funded reserves. Self-insurance is becoming more common. The Task Force is of the view that companies which opt to self-insure should be given incentives to accumulate reserves against future losses. The current taxation of such reserves, however, operates as a serious disincentive.

The Task Force recommends a change in tax laws to allow corporations to take tax deductions on "self-funded" reserves in the same way that an insurance company can on its claim reserves. This would encourage large corporations to retain more responsibility for their own risks. Such a change would be beneficial, provided that the amount of risk retained is compatible with the risk-bearing capacity of the corporation (or other business entity). Three important benefits accruing from this would be:

- (1) More insurance capacity would be freed up for those smaller business entities and/or individuals whose lower risk-bearing capacity renders them more dependent on insurance.

- (2) More insurance capacity would be freed up for new types of cover needed to respond to our changing environment and for catastrophe cover.
- (3) Greater levels of risk retention would, at least in the long run, lead to greater attention to loss prevention and control, which would benefit both the individual corporations and society as a whole.

Self-retention of these risks would eventually become a viable proposition for many larger corporations if they were able to set aside reserves, on a tax-deductible basis, in years when their losses were lower than the average for the period as a whole, in order to fund for those inevitable years when losses will be much greater than average. This is similar to what would be referred to in certain areas as a "claims stabilization" reserve and would increase the ability of firms to self-retain their own risks and thus increase the extent to which the benefits identified above could accrue.

This could have long-term benefits for society; it would be clearly beneficial if companies with a high pollution liability exposure were able - or even required - to set aside, in a trust fund, sums of money to cover the costs they will eventually have to pay for the damage they are causing to the environment.

The Task Force recognizes that certain controls would have to be placed on such reserves, including:

- (1) If reserves set aside for losses not yet paid are to be tax deductible, strict controls will be required to avoid abuse.
- (2) If corporations are to be encouraged to retain greater amounts of their own risk themselves, high standards of professional advice on the extent to which this is appropriate will be required.
- (3) To prevent abuse, some form of trust might have to be created for tax-deductible reserves.

The Task Force recommends that:

D.37 The tax laws should be changed to allow corporations to take deductions on self-funded reserves in the same way that an insurance company can on its claims reserves, subject to appropriate controls to avoid abuse.

Captive Insurers

In certain circumstances and with proper regulation, it is socially desirable to allow operating companies to make use of captive property and casualty insurance organizations. Under existing legislation and regulations, the use of captives has not been optimal. Moreover, because of tax considerations, most captives that have been used have been off-shore captives, frequently based in tax havens such as Bermuda and the Bahamas. If captives are to be used, there is merit in their being domestic, openly and properly integrated into the Canadian insurance scene, and subject to the regulation of Canadian authorities. In the United States, some states have encouraged the domestic domicile of insurance captives. The regulatory aspects of captives have already been considered in this report. In addition, the Task Force recommends that:

D.38 The tax treatment of captive insurance companies should be examined, alongside the regulatory aspects of such captives, with a view to promoting the domestic domicile of such captive property and casualty insurance companies as are considered to be an appropriate part of the Canadian property and casualty insurance markets.

Reserves (Stabilization and Major Shock Losses)

Finally, two tax matters related to the reserves of property and casualty insurers have come to the attention of the Task Force: insurer stabilization reserves and insurer contingency reserves for large shock losses. Historically, property and casualty insurers have not explicitly recognized a "premium deficiency" on their balance sheet; yet they have recognized such deficiencies in their internal rating and planning procedures. Although some companies already include premium deficiency reserves on their balance sheets, regulatory plans to require actuarial certification will force recognition of this item. The tax authorities, administratively, have allowed such provision of reserves as an item in reckoning taxable income in recent years but confirmation would be helpful.

The logic of such a practice is essentially the same as the provision by banks of reserves against bad and doubtful loans. The allowance of such reserves to property and casualty insurers would have to be subject to rules to prevent abuse, just as bank reserves are. The Task Force therefore recommends that:

D.39 Property and casualty insurers should develop, with the tax authorities, a set of rules for the deduction of premium deficiency reserves where an insurer has a premium deficiency reserve program and includes such reserves on its balance sheet and provision should be made for rules regarding additions to such reserves as an expense item for the measurement of the taxable income of the insurers.

- The other reserve and tax item regarding insurers concerns reserves for shock losses, such as the periodic wiping out of greenhouses, or other disasters. It has been recommended to the Task Force that property and casualty insurers be allowed to set aside as a reserve a small proportion of premium income into a reserve against major shock losses and that such charges to reserves be an expense in reckoning taxable income. The Task Force therefore recommends that:

D.40 The industry, the regulatory authorities and the tax authorities should explore means of improving the provision and use of reserves against major shock losses, related particularly to disasters due to natural causes, including the taxation treatment of such reserves.

VII A MORE ACTIVIST ROLE FOR GOVERNMENTS IN PROPERTY AND CASUALTY INSURANCE

Introduction

In addition to setting frameworks for, and regulating the operations of, private property and casualty insurers, governments all over the world take a somewhat more activist role from time to time. They lead, persuade, threaten, order and encourage the market operators to form pools and provide various services on different terms, sometimes but not always, with some government backup. They become residual insurers for particular risks or in special circumstances. They provide insurance services when there are extreme uncertainties, such as those arising from earthquakes, terrorism, floods, crime or war damage (and in Ontario, crop failures) when even very strong private markets cannot cope adequately. They may become the main deliverers of some

insurance services through a government monopoly insurance operation or in competition with private insurers (see List B below).

Canada has some or all of these activist experiences of governments in property and casualty insurance. The Ontario government has been more than a passive co-operator or regulator in the development of the Facility Association, the Spills Pool and the Ontario Liability Pool. The federal government has continuously been involved for decades with export insurance for difficult overseas trade risks (including sovereign risks) and export credits. The Ontario government has residual responsibilities regarding greenhouses, pollution and environmental risks. Four provinces operate government insurance corporations. The Task Force has been asked to make recommendations on a government insurance corporation for Ontario.

In this Part, the initial examination is of government insurance corporations because the establishment of such a corporation in Ontario would be the largest institutional change anyone has yet suggested in the delivery of property and casualty insurance. Next, more piecemeal options for government acceptance of risks and delivery of some or occasional insurance services will be considered. Finally, the important roles of government as animators in insurance services will be addressed.

The most important general message of this Part of the Report is that, if the private insurance institutions (which include mutuals, pools, co-operatives, joint stock companies and individual proprietorships) and partnerships perform insurance services inadequately from a social point of view, inefficiently and with a high degree of uncertainty and instability, then governments, and in particular the Government of Ontario, will inevitably be drawn into more activist roles for at least some property and casualty insurance services.

Government Insurance Corporations

Canada is one of the 16 countries in which there are stable government insurance companies that are in competition to some extent with private sector insurers. They are the following:

Saskatchewan Insurance Company: monopoly supplier of the compulsory portion of automobile insurance and a competitive supplier of optional automobile insurance and of general insurance.

Manitoba Insurance Corporation: monopoly supplier of the compulsory portion of automobile insurance and a competitive supplier of the optional part of automobile insurance and other general insurance.

Insurance Corporation of British Columbia: monopoly supplier of the compulsory portion of automobile insurance and a competitive supplier of other automobile insurance; no longer a supplier of general insurance.

Régie de l'assurance du Québec: monopoly supplier of the compulsory bodily injury benefits associated with the use of automobiles.

The Task Force has reviewed the documentation on these corporations and engaged in direct discussions with each of them, and the Chairman of the Task Force has prepared a personal report that is of greatest relevance to the consideration of a government insurance corporation in Ontario. This is included in the Report as Appendix 19.

In order to consider clearly the merits of establishing a government insurance corporation in Ontario, some misinformation and confusion have to be cleared up at the outset. The most important is the distinction between the design or content of the insurance services that are desired in Ontario and the means of providing the services. Most of the discussion concerns auto insurance; we shall initially concentrate on that domain, but later consider other risks and insurance services.

The design of an auto insurance system and the means of delivering the system are very largely separate issues. Many people would like to have an improved set of no-fault accident benefits relating to bodily injury in the Ontario system. There is no need to have a government insurance corporation to accomplish such a change in the design of the insurance services. Many people would like to see a rating system for auto users based on driving and accident

experience, rather than on age, sex and marital status. Lower insurance premiums for young unmarried men with good driving records is the desire of many people. There is no need to have a government insurance corporation to accomplish such a change in the design of the insurance services. Many people would like to have some improvements in the distribution system and in the information system. Again there is no need to have a government insurance corporation to accomplish such an improvement. The central question is whether, for the same basic design of auto insurance services, a private system, such as exists and can evolve in Ontario, can deliver the product more efficiently, with less difficulty and frustration, with lower transaction and legal costs, and with greater responsiveness to the diverse tastes of the public than a government corporation.

The Chairman considers the following to be a fair-minded evaluation of the facts. **First**, when the government insurance companies in Canada have been well run and not overburdened by social missions and unreasonable restraint on their premium rates by their masters, they have been quite efficient. They have all been efficient performers in recent years. They have also managed to achieve a few social goals as well as provide good-quality insurance services.

Second, when comparisons have been made, as best one can, on the basis of "apples with apples", they have shown that in recent years government insurance companies have managed to put a little more of the revenue dollar into claim payments than on average private insurers have in Ontario.

Third, the advantage is not much. Some companies in Ontario are very efficient by any standard. The good performance of the government corporation may well be temporary as the signs of increased litigiousness have appeared in the western provinces, all of which operate with a mixture of no-fault and tort compensation schemes. The combination of contingent fee lawsuits and the advertising of legal services in British Columbia especially raises worries about the cost trends of insurance in that province.

Fourth, the government insurance corporations do appear to reduce the choice open to the citizens and the competition in service to customers.

Fifth, all of the government insurance corporations have had at least one period of unsatisfactory performance, even in automobile insurance. All of

them have had more frequent and serious difficulties in general insurance.

Sixth, the data and analytical systems in the government insurance corporations have been impressively efficient, using state-of-the-art technology. This is especially true of the Insurance Corporation of British Columbia. Such systems have been a major factor in the relatively good performance of these corporations in the recent insurance cycle.

Seventh, this has to some extent been offset by the losses experienced by both the Manitoba and Saskatchewan corporations in reinsurance in recent years.

Finally, compulsory auto insurance and personal lines property insurance, which have been the staples of the government insurance corporations, are not the centre of the greatest problems in property and casualty insurance in the 1980s in any case. And even the important automobile insurance questions are about design, not delivery mechanisms. Thus government insurance corporations deliver the existing design of automobile insurance, and compensation does not appear to be the top priority for a (perhaps necessary) activist role of governments in of property and casualty insurance.

In view of these evaluations the Task Force recommends that:

- D.41 The Government of Ontario should NOT establish at this time a government insurance corporation to deliver auto insurance services.
- D.42 The Government of Ontario should concentrate its efforts regarding auto insurance on improvements in the design of the system set out in Part C, which it is contemplated will be delivered by an evolving private insurance market system;
- D.43 If the Government of Ontario does choose, for a balance of political and social reasons, to establish a government insurance corporation to deliver auto insurance services, it should take steps as indicated in the Chairman's memorandum to try to ensure a "good performing" rather than a "poor performing" government corporation. This is not a simple or easy task.

Two other general considerations also bear on the establishment of a government auto insurance corporation in Ontario. Governments have limited political capital and energy. Some selection of more important subjects for their

efforts is highly desirable. The Chairman of the Task Force suggests that there are more important insurance issues than government delivery of auto insurance that require attention.

The other consideration arises from the fact that Ontario is, more than any other province, the centre of the nation's capital markets and financial services. The consequences of nationalization or provincialization of much of the property and casualty insurance industry in Ontario for the overall attractiveness and effectiveness of the broader financial functions should be considered.

These recommendations do not imply a laissez-faire approval by the Governments of Canada and Ontario to a number of enduring structural issues of property and casualty insurance, to which we now turn.

Activist Roles for Governments with Respect to Structural Problems

Governments as Animators in the Property and Casualty Insurance Market

The role of government as an animator regarding general insurance can be distinguished from its roles as a regulator, a marginal or fringe participant in delivery systems and a mainline deliverer of services. As animator, government is mainly assisting the private institutions and participants in market processes. Operating market assistance programs and information hot lines, assembling and informing interested parties, providing a little "tender loving care" to new institutions in their formative stages, promoting improved data and analytical systems -- these are the kinds of activities comprising animation.

Regarding animation, some historical perspective is important. Governments of all ideological stripes in virtually all parts of North America, Western Europe, Japan and the Commonwealth have played some animation role in general insurance for many decades. Animation is not a recent or hypothetical or especially Ontario affair. However, for the Task Force it is Ontario's experience and possibilities that are of primary concern.

What are the fundamental bases for governmental animation activities in relationship to general insurance? Why do governments intervene or feel they have to intervene to "help" the private markets? The answers are on two levels: one, broadly political or social; and the other, operational.

If governments are going to impose mandatory insurance requirements on segments or activities under their jurisdictions (e.g., compulsory automobile insurance, compulsory liability insurance as a licence condition for professional practice), then governments have to ensure that the service is available, even if in some circumstances private markets have difficulty providing the service. Animation may be required to overcome some of the reluctance of a private market to provide the full range of required services to all the participants who are subject to the requirement.

Still, on the broadly political or social level, general insurance services are so pervasive and vital to so many people, quite apart from standards imposed by governments, that governments cannot be expected to stand idly by if groups in society have difficulties with the availability, price, affordability and accessibility of insurance. Society expects and demands help, at least of an animatory kind.

On an operational level, three considerations underlie government intervention, even if only of the animation type. First, a private market arrangement, all on its own, may have real difficulty in internalizing the costs and benefits of some activities. The activities would not be done or done adequately without some collective action being organized. Second, there may be severe obstacles to collective action by the private players, arising from legislation or rules or fear of allegation of cartel activities, or other activities in restraint of trade. Government animation may overcome this problem. Third, there may be disincentives for change resulting from structure or patterns of behaviour that are too entrenched to be changed by the private players themselves.

Virtually all reasonably developed countries have social security insurance. The major exceptions are Moslem countries, where of course Islamic law requires that the family care for the aged and sick. In addition, all developed industrial countries have export credit guarantee insurance provided by governments. Some countries such as Brazil require primary insurers to place their business with a government reinsurer (see List A below). Presumably, these countries are attempting to keep funds within their jurisdiction, rather than provide extra capacity.

The most important feature of our study concerns special catastrophe insurance that is provided by governments. This insurance is prevalent among developed countries, which do not necessarily have socialist regimes. Examples are contained in List A. In studying List A, one is struck by the following features:

- (1) Each of the perils insured against is indeed one that is naturally associated with that country (eg., Japan, earthquakes).
- (2) The insurance is provided, not on grounds of politics, but on grounds of need.
- (3) Insurance is not particularly widespread.

The special risks to which the province of Ontario is prone should also be considered in the light of these special catastrophe insurances provided by other governments. It would seem reasonable to assume that:

- (1) Ontario is one of the jurisdictions in the world most reliant on exports; and,
- (2) Ontario exports into the most litigious country in the world (i.e., the United States).

These two features combined are, it seems, special to Ontario. Thus, some form of export liability insurance should be seriously examined by the Ontario government. Such a program would encourage exports by Ontario manufacturers and service industries, provide a cutting edge in competing with American manufacturers and reduce the overall exposures for most Ontario businesses.

The other enduring structural problems of liability insurance in Ontario which have been identified to the Task Force (and reported earlier and in Appendix 18) include pollution and environmental risks, the services of the provinces and its creatures (municipalities, school boards, utility boards, etc.), professional services and services of volunteers. For many of these the industry alone may not be able to cope effectively in the next few years.

Accordingly the Task Force therefore recommends that:

D.44 The Government of Ontario should consider a more activist role in insurance and reinsurance, in association with the industry, to meet the difficult structural problems of uninsurable risks and uncertainty, particularly as regards products liability (especially in relation to exports to the United States), pollution and environmental risks, the services of the provinces and of its creatures, professional services and voluntary activities. Some of these problems appear to be enduring rather than transitory, and a government insurance corporation may well be an appropriate vehicle for helping to deal with these problems.

The Government of Ontario has been active as an animator in insurance markets, particularly during the last year. In this Report, the Task Force reviewed the government's role in promoting the development of the Facility Association, the Spills Pool, the market assistance programs and the Ontario Liability Pool; encouraging and assisting the development of new pools, reciprocals and mutuals; promoting of the Canadian Insurance Exchange; developing a compensation fund; and improving the data systems and analysis. The federal and Ontario governments have been involved in helping the industry to solve problems for general insurance companies that had difficulties.

These activities appear to be meritorious, and a number of them appear to have been rather well done under difficult circumstances. The Task Force appreciates how difficult the problems of balance and continuing involvement are in such activities. Neither the government nor the industry wants to stifle the development of ongoing private sector developments. Yet the very fact of government involvement permits the public and the industry to pass their more difficult problems over to government. Once the government is providing a service, it may be hard to stop providing it.

LIST A**Forms of Insurance Provided by Governments****A. Insurance Virtually Totally Controlled by Government**

All Eastern Bloc Countries
Columbia
Nigeria
Pakistan (life insurance only)
Peru

B. Well-Developed Social Security Insurance Systems

Virtually all countries except

Brazil
Chile
Hong Kong
Indonesia
Republic of Korea
Morocco
Pakistan
Saudi Arabia
Singapore
Republic of South Africa
Taiwan
Turkey

C. Competing State Companies (to Some Degree)

Australia
Canada
France
Ghana
Greece
Indonesia
Mexico
New Zealand
Pakistan
Portugal
Spain
Switzerland

D. Compulsory Life Insurance for Civil Servants

Argentina
Philippines
Taiwan

E. Compulsory Reinsurance with a Government Reinsurer

Brazil
Ghana
Kenya
Malaysia
Morocco

F. Catastrophe Insurance Provided By Governments

Iceland	-	all catastrophes
Israel	-	war damage
Japan	-	earthquake
New Zealand	-	earthquake or war
Philippines	-	crop failure
Republic of South Africa	-	riot and malicious damage
United States of America	-	flood and crime

G. Export Credit Guarantee Provided by Governments

Austria	Israel
Bahamas	Italy
Belgium	Japan
Canada	Luxemburg
Cyprus	Malaysia
Denmark	Norway
France	Rep. of South Africa
Hong Kong	Sweden
Iceland	Switzerland
India	United Kingdom
Ireland	West Germany

LIST B

**Forms of Insurance Provided by
Canadian Governments**
(excludes health insurance)

A. Automobile

Quebec - third party only
Manitoba
Saskatchewan
British Columbia

B. Export Credit Guarantee

Federal

C. Mortgage Guarantee Insurance

Federal -- CMHC

In competition with the Mortgage Insurance Company of Canada.

D. Property

Manitoba
Saskatchewan

E. Workers' Compensation

All provinces, but not the Yukon or the Northwest Territories, where it is provided by the private sector.

F. Crop Insurance

See, for instance: Crop Insurance Act, R.S.O. 1980, c. 104.

CONCLUSIONS

CONCLUSIONS

Summary of Conclusions

The Task Force has concluded that:

- o Risk and property and casualty insurance in Canada are undergoing fundamental structural changes.
- o These changes are rooted in technological, social and judicial changes that have altered and destabilized the risk environment.
- o These changes have not only increased the risks for which insurance is sought, but have introduced massive increases in uncertainty.
- o The property and casualty insurance industries have been attempting to adapt to these changes, while at the same time carrying an enormous baggage of insurance problems over from past contracts, many of them going back decades.
- o The problems generated by the changes to the risk environment have been exacerbated by the effects of the insurance "cycle" as the industry shifts from a "soft" to a "hard" market.
- o The concentration of both structural and cyclical difficulties has been greatest in general liability insurance. The ultimate impact of the insurance cycle is also disproportionate because of severe perception and response lags within the industry; these lags are due to the poor level of information and analysis generated by, for and about the industry; improvements in this area would significantly improve industry efficiency and economic responsiveness.
- o The "hard" market phase of the current insurance industry cycle was delayed, and muffled particularly in Canada, by unusual reinsurance and investment income factors; eventually, however, a wrenching and disproportionate market adjustment took place.

- o Because of the current fragmented structure of the industry, when cyclical adjustments in price and retrenchment of markets do take place, the re-establishment of a satisfactory price-cost relationship is generally slow; indeed, the current crisis indicates that cyclical over-adjustment in price and availability of insurance continues to be the norm.
- o A hangover in underwriting losses in other lines of insurance, particularly for bodily injury, also exists.
- o The increasing size and unpredictability of judicial awards and extra-judicial settlements for bodily injuries, arising from accidents of all kinds, are of great concern in the United States; this concern has prompted hundreds of proposals in the United States for tort reform, mainly by the legislative branch of governments, desirous of asserting more control over the compensation process by imposing limits on tort awards.
- o Regarding risks, awards and insurance, Canada is far from becoming a "California of the North" -- however, the developments in the risk environment, in the expanded interpretation of liability, and in the dramatic increase in the value of awards and settlements in Canada are similar to the American developments, and have the same fundamental causes.
- o The lack of systematic data on awards and settlements in Canada has caused great difficulties both in understanding the real situation in Canada and in explaining the differences from the American situation.
- o Although many participants are rightfully proud of what has been accomplished within the tort/litigation system in Canada during the last few decades virtually no one is satisfied with the status quo.
- o Many thoughtful and constructive suggestions have arisen for tort reform in Canada; most contemplate modest steps designed to improve the fairness and efficiency of the tort/litigation system in Canada, and to thereby enhance the predictability of risk and the ability of the insurance industry to serve the public.

- A number of these proposals have immediate merit, but others require more careful study.
- An impressive case, however, has been made for more fundamental structural changes to the current Canadian accident compensation and system.
- Therefore serious research and planning work should be undertaken in Canada, and in particular in Ontario, anticipating fundamental reforms to the current accident compensation and deterrence systems.
- The case for significantly improving Ontario's current automobile accident benefit system is even stronger; the Task Force recommends immediate discussions between the industry and the Government of Ontario to design and implement a comprehensive no-fault automobile accident benefit system.
- The Task Force has recommended against the immediate establishment of a government insurance corporation for the provision of the compulsory elements of automobile insurance. The Task Force suggests that there are other more important insurance matters in Ontario that are deserving of the government's political capital and energy. The Task Force also believes that these requirements can be adequately supplied by private industry.
- Another matter that requires urgent attention is the introduction of claims-made policies in the field of general liability insurance.
- It appears unlikely that completely autonomous private market actors will be able to provide satisfactory property and casualty insurance services in the near future for some problem areas. More specifically, government assistance may be required in the following areas: product liability insurance for exports to the United States, some areas of professional liability, municipal insurance, voluntary sector insurance and insurance for environmental damage and pollution liability.

- o The regulatory framework for the property and casualty insurance industries requires improvement in the following areas: solvency requirements; financial management standards; disclosure requirements; incentives to generate information, and market service performance standards. The Task Force has reviewed all the proposals extant and has suggested its own regulatory package.
- o Risk limitation and control has been relatively neglected in a number of activities in Ontario. A more systematic, integrated risk management and insurance approach should be encouraged.
- o Finally, a Legislative committee should be established to review, at least annually, the performance of the property and casualty insurance industries in Ontario; in addition, this committee's mandate should include a consideration of judicial awards, extra-judicial settlements and the transactions costs for each compensation mechanism.

The Urgent Need for More Statistical Analysis and Information

The gaps in statistics and analysis have been touched upon at many times in the Report. But the Report would not be complete without one more cri-de-coeur for a major effort at improvement.

Over and over again, the Task Force has had to argue that in matters of property and casualty insurance Ontario is not a "California of the North". Skeptics keep demanding hard evidence, not lessons in comparative civics. But for far too many critical matters the evidence is non-existent or inadequate.

Over and over again, the Task Force was told that the cost of insurance had increased because of social inflation in awards and settlements, in and out of courts. Almost as frequently, the Task Force was told that there had been no increases in real terms in awards and settlements. In response to this debate the Task Force is confident that there has been a significantly higher rate of increase in awards and settlements than the average increase of inflation rates. However, the Task Force's conclusion is basically qualitative. Without additional data and analysis nothing more was possible. Indeed without more information,

hypotheses of all sorts remain unchecked and unverifiable. More importantly, the defenders of the status quo will be able to continue to assert that there is no evidence to support any criticism or proposals for change.

The information gaps are not quite so serious for the evaluation of the solvency, reserve, and profitability of insurers. Much of the relevant material is published by, or under the authority of, the Superintendent of Insurance from the Annual Statements that insurers must file. However, there remain important gaps even on these matters. The schedule for the new reporting forms that are proposed for general usage in 1986, will improve the situation. Actuarial certification of reserves would also assist, if and when that practice comes into general use.

One of the main gaps in statistics and analysis concerns legal costs broken out from claims paid by the insurance companies. At present, it is all too easy for accusations to be made that legal costs are the dominant part of the whole set of transactions costs, and that they eat up an inordinately high proportion of both the premium and the revenue dollar. In the United States, it is common to encounter assertions that legal costs eat up 75 per cent of the premium dollar in liability insurance. Until reliable statistics are available and careful analysis is made of the role of legal costs in the Canadian property and casualty insurance chain, it will not be possible to answer such accusations. More importantly, without such information it will be impossible to compare the costs of alternative adjudication and dispute resolution processes.

Another gap in the statistics and analysis is presented by the inadequacy of information on which to evaluate the cost-benefit experiences of risk management and control efforts such as safety programs, and improved safety of products, etc. There are some examples in Canada where such data are available and where careful analysis has been possible. These examples demonstrate the remarkably high pay-off that can be attained from some safety programs.

A number of other deficiencies in statistics and analysis have turned up in the work of the Task Force: specifically, data on accidents other than automobile or industrial; integrated data bases needed to run an efficient and fair bonus-malus system; and even data on the price and availability of some insurance services.

For an industry that depends on numbers, and that does such an impressive job in assembling and analyzing data for many rate-making purposes, the gaps in statistics and analysis sketched above are puzzling. For reasons which the Task Force was not able to fathom, statistical and analytical exercises, which are both possible and could be done economically with modern information technology, are either not done, or are done incompletely and ineffectively.

The Task Force suggests that the industry associations and the government authorities make a special effort to develop statistical and analytical programs to fill most of the gaps noted above. Much the same plea was made about a decade ago in the excellent reports of the Select Committee on Company Law. Not much has happened in the intervening decade. In this crisis, the public and the industry have suffered more than they needed to, in part because of the confusions resulting from the gaps in statistics and analysis. It would be unfortunate if a Task Force or a Legislative Committee a decade from now had to repeat this plea.

SUMMARY
OF
RECOMMENDATIONS

SUMMARY OF RECOMMENDATIONS

PART B: THE CRISIS IN LIABILITY INSURANCE

RESPONSES TO THE CRISIS AND PROPOSALS FOR REFORM

Claims-Made Policies

- B.1 The industry should take immediate steps to ensure clear and timely explanations of the scope and application of the claims-made policy are provided to insureds directly, and through brokers and agents.
- B.2 The Superintendent of Insurance should be accorded wider powers of regulation in respect of the approval of commercial general liability policy forms, with a view to imposing minimum standards and to preventing potential abuse of the claims-made form by insurers.
- B.3 The Government of Ontario should undertake a review of all statutes requiring minimum commercial general liability insurance coverage to determine if any additional provisions are required in the case of a claims-made policy form, such as mandatory tail coverage.
- B.4 Specific attention should be given to the claims-made policy form in establishing regulations with respect to minimum notice periods for non-renewals of coverage, mid-term cancellations and changes in coverage. (See Recommendation D-29.)

Environmental Impairment and Pollution Exclusions

- B.5 Consideration should be given to requiring the companies engaged in environmentally hazardous activities to set aside reserves to cover potentially catastrophic pollution events. Such reserves should be tax-exempt (see also Recommendation D.37).
- B.6 The Government of Ontario should take steps to encourage the formation of an industry-based pool to accommodate currently uninsurable risks such as leaks from underground storage tanks involving fuel at service stations, home heating and oil, and industrial storage of fuel and other raw material products.
- B.7 The Insurance Act should be amended to make clear that insureds such as oil companies are permitted to indemnify members of their sales associate network and other non-affiliated companies and contractors in the event they suffer losses for which insurance protection is either unavailable or prohibitively expensive such as coverage for underground tank leaks and other pollution-related exposures.

- B.8 The Superintendent of Insurance should work with the insurance industry to develop adequate provision for "sudden and accidental pollution coverage" within the Comprehensive General Liability policy, and if necessary, address the problem by way of minimum statutory conditions.

Legal Defence Costs

- B.9 The Superintendent of Insurance should examine the treatment of defence costs under the Commercial General Liability policy and, if necessary and appropriate, make recommendations to the government for appropriate action to enhance the protection of the insured.

PROPOSALS FOR NEW FACILITIES AND ENHANCED CAPACITY

Reciprocals

- B.10 The Superintendent of Insurance should continue to encourage the establishment of reciprocal insurance exchanges in appropriate cases, and should prepare a booklet describing the nature of reciprocal exchanges, their potential advantages and the statutory requirements under the Insurance Act designed more specifically for commercial entities.
- B.11 The provisions of Part XIII of the Insurance Act should be updated and clarified with respect to the obligations of subscribers or members of reciprocal exchanges.
- B.12 The Superintendent of Insurance should request a ruling from Revenue Canada on the taxation of reciprocal exchanges and make available a commentary prepared by Revenue Canada to interested persons.

Insurance Pools

- B.13 The insurance industry should be encouraged to continue to adopt pooling measures as required from time to time.
- B.14 The Government of Ontario should continue to be prepared to act as the facilitator of industry-based insurance pools when capacity crunches emerge from time to time.

Export Liability Insurance Pool

- B.15 The Government of Ontario should give strong consideration to sponsoring an insurance industry pool, the terms of reference of which will be carefully drawn up so as to restrict assistance to those exporters experiencing a severe availability, adequacy and affordability crunch, and to avoid any appearance of subsidizing inefficient producers and manufacturers. The pool should be administered by the industry and include a hot-line service. Government financial assistance might be provided by way of reinsurance of the last resort, or guarantor of retrospective rates

and excess losses when the capacity even within the pool proves inadequate and where the situation so demands in accordance with prearranged guidelines.

New Mutuals

- B.16 The Superintendent of Insurance should ensure that greater information on the possibility of creating mutual or cash mutual insurance corporations as viable mechanisms for expanding capacity, be provided to the public.

Expansion of Farm Mutuals

- B.17 The proposals of the Ontario Mutual Assurance Association should be proceeded with as quickly as possible. These proposals will give farm mutuals the same investment powers as other insurers, and the ability to form subsidiaries designed to provide commercial and urban insurance coverages. Such subsidiaries should be subject to capital requirements, regulations and taxation comparable to those applying to joint stock property and casualty insurers. At the same time, the guarantee fund of the farm mutuals must be extended to their subsidiaries to ensure adequate protection of the public.
- B.18 Farm mutuals should also be required to conform to the same rules for financial reporting and disclosure as other insurers.

Extended Functions of Captive Insurers

- B.19 The Government of Ontario should take steps to facilitate the formation of domestic captive insurance companies and the Insurance Act should be amended to extend to such captive insurers. The new provisions should permit sophisticated buyers of insurance to form their own insurance companies with a minimum of regulatory oversight.
- B.20 Revenue Canada should be requested to review its position vis a vis captive insurers, and the federal government should be urged to make any appropriate changes to the Income Tax Act if necessary.

Self-Insurance

- B.21 The Government of Ontario should request the federal government to amend the Income Tax Act to permit corporations to take tax deductions on self-funded reserves in the same way that an insurance company can on its claim reserves.

Insurance Exchange

- B.22 The Government of Ontario should take immediate steps, with the support of its federal and provincial counterparts, to establish the Canadian Insurance Exchange in time to take advantage of the reinsurance treaty renewal period commencing January 1, 1987.

THE CALL FOR TORT REFORM

Some Interim Measures

- B.23 The Government of Ontario should consider taking action to introduce changes in the spirit of the proposals reported above on pre-judgement interest, gross-up and structured settlements, and joint and several liability and limitations. The Government should consider the treatment of collateral benefits in connection with recommendations C.1 and C.2 below for reform of the compensation for bodily injury due to auto accidents. The Government should give prompt consideration to the risk and liability problems of volunteers. The industry and the Government should seek to develop and apply arbitration as an alternative method of dispute resolution in accident compensation cases.
- B.24 The Government of Ontario should develop and implement, with the co-operation of the industry, a statistical plan for the gathering of data and the analysis of awards and settlements of compensation for accidents, including the components that are used in building up overall awards or settlements.
- B.25 The OLRC study should expand its mandate to include each of the eight reform areas that were discussed above. In particular, the question of joint and several liability, appropriate limitation periods, the need for Good Samaritan legislation, and the arbitration of accident benefits, should be added to the OLRC personal injury study.
- B.26 A parallel study should be commenced by the OLRC to address problems that go beyond the personal injury area and that relate to liability under the tort system in general, particularly in the professional liability sphere. The Task Force will ensure that the OLRC obtains a copy of the Lilly study and related briefs and papers so that such questions as concurrent liability, joint and several liability, appropriate limitation periods, incorporation by professionals and other matters raised therein can be studied in a careful and systematic way.
- B.27 The work of the Ontario Law Reform Commission in both of these areas should be accelerated so that its final report can be made available as soon as possible.

THE NEED FOR A FUNDAMENTALLY DIFFERENT APPROACH TO ACCIDENT COMPENSATION

- B.28 In the short term, a new accident compensation scheme should be implemented by the private insurance industry at least for automobile accident injury. (This proposal is developed in more detail in Part C below.)
- B.29 Ideally and as a medium-term objective, government should begin to work with the private insurance industry to design a universal accident compensation plan that would include compensation for all accidental injuries.
- B.30 Eventually and in the longer-term, federal and provincial governments should begin planning the co-ordination and rationalization of all existing first-party no-tort compensation schemes into a universal disability compensation program.

PART C: OTHER INSURANCE ISSUES

AUTOMOBILE INSURANCE

Options for Reform of the Automobile-Related Personal Injury Compensation System in Ontario

- C.1 The Government of Ontario should work with the insurance industry to devise the framework for the private delivery of the new system of personal injury compensation recommended herein. Particular emphasis should be placed on ensuring the provision by the industry of adequate layers of first-party insurance coverage above the minimum mandatory compensation levels, as well as ensuring access to adequate rehabilitation services. In addition, the industry, with the assistance of the Government, should establish a pooling mechanism such as a catastrophic claims fund to ensure that all insurers, regardless of size, be in a position to meet their obligations to provide first-party coverage in respect of victims of catastrophic injury. The Facility Association can perhaps provide the necessary mechanism. Finally, the Government must ensure that the industry establishes adequate dispute resolution mechanisms, whether by way of expeditious arbitration or otherwise.
- C.2 The Government of Ontario should then introduce a mandatory system of auto insurance for personal injury compensation whereby all insureds purchase a basic minimum level of insurance including coverage for loss of income, costs of care, and unlimited rehabilitation and medical expenses. The minimum level for loss of income should be set at a level such as to cover a clear majority of the population of Ontario, and should be subject to the appropriate cost of living indexation formula, and to an annual review by a committee of the Legislature. Where considered appropriate, insureds could purchase additional layers of income replacement coverage on an individual or group basis.

- C.3 The Government of Ontario should consider elimination of resort to tort/litigation system with respect to personal injury compensation from automobile accidents; or
- C.4 The Government of Ontario should consider substantially limiting resort to the tort/litigation system with respect to personal injury compensation from automobile accidents, by way of a threshold.
- C.5 In conjunction with the introduction of a new system of personal injury compensation, the Government of Ontario should work with the insurance industry on an urgent basis to enhance the deterrent to hazardous driving, and to implement an effective bonus-malus system for setting automobile premium rates. At the same time, the Attorneys-General of both Ontario and Canada should be strongly encouraged to continue their efforts to ensure more appropriate criminal penalties in respect of unsafe driving.
- C.6 To ensure the effectiveness of the bonus-malus system, the Government of Ontario should work with the industry to devise a plan to create an integrated data base to provide drivers' claims histories, conviction records and driving experience, and explore how to make this essential information available on an on-line basis.

Automobile Rate Structure

- C.7 The Superintendent of Insurance together with his counterparts on the Canadian Council of Superintendents of Insurance should take the necessary action to ensure that all automobile insurers in the various jurisdictions comply with the reporting requirements under the Statistical Plan as amended on January 1, 1985.
- C.8 The Government of Ontario should encourage its provincial counterparts to support a uniform date between January 1, 1989, and September 1, 1989, for the implementation of the elimination of age, sex and marital status criteria. This should give the industry adequate time to collect and analyze data, and be ready to apply appropriate alternate criteria.

Rate Regulation

- C.9 The Compulsory Automobile Insurance Act should be amended to clarify and extend the Superintendent's regulatory power to the non-compulsory component of coverage in respect of both rate levels and classifications and surcharges used by the Facility Association.
- C.10 The Superintendent of Insurance should undertake immediate steps together with the insurance industry to explore the implementation of a mandatory basic classification system, at least with respect to compulsory automobile insurance, with a view to its broader application if appropriate. This would take place in conjunction with the elimination of age, sex and marital status criteria as recommended above.

Self-Insurers and the Compulsory Automobile Insurance Act

- C.11 Municipal corporations and other public authorities in Ontario that establish, either on their own or with other municipal corporations or public authorities, an adequate plan with appropriate financial guarantees to the satisfaction of the Ministry's officials, should be entitled to apply to the Minister for the appropriate exemption from the Compulsory Automobile Insurance Act, and that the terms of the plan, as approved, should be set forth in the exempting regulations.

PERSONAL AND COMMERCIAL PROPERTY INSURANCE AND OTHER LINES

Personal Lines

- C.12 The guiding principles of the Industry/Government Committee should be reaffirmed and circulated periodically, to remind those in the insurance industry of their obligations with respect to the rejection of an application or cancellation or refusal to renew a policy because of the physical condition of the property, and that indiscriminate rejection of insurance applications by reason of area be discontinued.
- C.13 The insurance industry should seriously consider, on an urgent basis, ways to provide a greater choice of options and flexibility to both the homeowners' and the tenants' package policies.

DISTRIBUTION SYSTEM

The Problem of Accessibility

- C.14 The Superintendent of Insurance should monitor the situation closely and work with the Insurance Bureau of Canada, the Insurance Brokers Association of Ontario, and other relevant industry associations to ensure the development, application and enforcement of adequate guidelines to govern the broker/insurer relationship, including the orderly transfer of business from terminated agencies.
- C.15 All independent brokers and captive or exclusive agents should be required to disclose to the public the extent of their capacity to sell various types of insurance products and the products of a variety of insurers.
- C.16 The Superintendent of Insurance should actively encourage the insurance industry to permit and facilitate networking procedures among brokers, provided that the originating intermediaries provide much more accurate underwriting information to those in the network, and that the network be set up in such a way that insurers be approached only once with each submission. Disclosure of networking activities should be part of the procedures to protect against possible abuse of networking activities.

More Effective Communications

- C.17 The Government of Ontario should assist the associations of agents and brokers to offer educational and licensing programs that meet the challenges created by the emergence of new and innovative products and services, and that improve the capacity of their members to assess the soundness of the institutions concerning whose products they advise the consumer. This recommendation was also put forward by the Dupre Task Force. The reference to the ability to assess the financial soundness of insurers is particularly critical given the new statutory duties to be imposed on the brokers under the proposed Compensation Fund legislation (Bill 108).
- C.18 The insurance industry should be actively encouraged to pursue joint projects, such as those carried out under the aegis of the Centre for Study of Insurance Operations, much more aggressively.

Inadequate Industry Data Bases

- C.19 The Superintendent of Insurance should work closely with the insurance industry, particularly the Insurance Bureau of Canada and Insurers' Advisory Organization, to improve the collection of statistics in respect of non-automobile commercial lines of insurance, and to mandate the collection of specific data and information in a similar way to that currently in place in respect of automobile statistics.
- C.20 Strong consideration should be given to the establishment of a body parallel to the United States Consumer Product Safety Commission, which operates the National Electronic Injury Surveillance system (NEISS). All emergency wards of major U.S. hospitals are plugged into the NEISS system, which feeds in data on product-related injuries. In this way a much more effective statistical base and early warning system with respect to potential areas of product liability can be built up. Similar statistics on occupiers' and professional liability should also be collected and analyzed more systematically and comprehensively.

Commission Rate Structure

- C.21 Insurers and brokers should consider the establishment of a sliding scale for commissions based on class and premium. Such a scale should take into account the amount of servicing required. The changes should be implemented by July 1, 1987; at the latest.
- C.22 With respect to large risks, strong consideration should be given to a "fee-for-service" as an alternative to or in combination with the present commission rate structure, bearing in mind that the acquisition costs to the intermediary, as well as the servicing, risk management and loss prevention costs are relatively high.

C.23 All independent brokers and captive or exclusive agents should make available to customers upon request the commission schedules that apply to the various lines of property and casualty insurance which they handle.

Providing Capacity and Availability in all Areas of the Province

C.24 The Government of Ontario should strongly consider the establishment of a government-sponsored residual market mechanism to ensure the availability of adequate, affordable insurance in all parts of the province. Consideration should also be given to the establishment, in conjunction with the insurance industry, of a toll-free province-wide enquiry and placement service.

TRANSACTIONS COSTS

C.25 The Superintendent of Insurance should be directed to work with the Canadian Council of Superintendents to implement the necessary modification to the statutory financial statements to require disclosure, for publication, of segregated legal and adjustment costs, as well as the net percentage of premium dollars returned to claimants in the form of claims benefits for the immediately preceding year.

PART D: THE ROLE OF GOVERNMENT

FINANCIAL REGULATION

Initial and Ongoing Capital Requirements

- D.1 The statutory initial minimum capitalization requirement should be increased to \$5 million for new federally incorporated property and casualty insurance companies and to \$3 million for Ontario-licensed property and casualty insurance companies.
- D.2 Consideration should be given to the particular situation of existing small insurers, farm mutuals, new mutuals and reciprocal exchanges in implementing the minimum initial capital and surplus requirements.
- D.3 The appropriate federal and Ontario legislation concerning capital and surplus margins of property and casualty insurers should be amended to provide that the ongoing capital and surplus margins would have to be at least equal to the greatest of:
- (a) the existing requirements of section 103 of the Canadian and British Insurance Companies Act;
 - (b) 15% of the gross premium income of the company during the immediately preceding 12-month period plus the smaller of \$500,000 or 5 per cent of the premiums; and

- (c) 22 per cent of the average annual amount of gross claims and claims adjustment expenses incurred by the company during the immediately preceding 36-month period plus the smaller of \$500,000 or 7 per cent of the said average amount;

provided that, in the case of (b) and (c), a maximum reinsurance credit of 50% is allowed for companies not limited to the business of reinsurance.

- D.4 Consideration should be given to the particular situation of small insurers, farm mutuals and new mutuals in implementing the minimum continuing capital and surplus requirements.
- D.5 The initial and ongoing capital requirements recommended above should be applied to each property and casualty insurer without regard to the capital of other corporations with which it may be related or affiliated.

Ownership

- D.6 The federal and provincial governments should retain their current approach to foreign ownership of property and casualty insurance companies.

What financial activities can be carried on by general insurers?

- D.7 Statutory and regulatory roadblocks to networking among the different types of financial institutions should be removed and appropriate statutory prohibitions on tied selling should be implemented.

Investments

- D.8 The investment provisions of the legislation governing federally-regulated companies and Ontario-incorporated companies should be amended to incorporate prudent management standards and the detailed quantitative, not qualitative limits, proposed in the Blenkarn Report.

Reinsurance

- D.9 Each primary insurer, where appropriate, should be required, by statute or by regulation, to retain a minimum percentage of its total gross premiums written, such percentage to increase in prescribed amounts of an annual basis over a specified number of years until it reaches at least twenty-five per cent of such premiums.
- D.10 The federal and Ontario Superintendents of Insurance should give early priority to a reconsideration of the statutory and administrative rules or guidelines governing reinsurance provided by non-registered reinsurers with a view to increasing the degree of security maintained by non-registered reinsurance in Canada in respect of their obligations to Canadian primary insurers.

Reserves

- D.11 Property and casualty insurance companies should be required as soon as possible, subject to appropriate transitional provisions, to appoint a valuation actuary and to include with their annual statement and financial statements a report by the actuary certifying that the provisions for unearned premiums and unpaid claims are adequate.

Self-Dealing

- D.12 Property and casualty insurance companies should be permitted to engage in non-arm's-length transactions except those that are likely to have a significant impact on a company's solvency.
- D.13 The prohibited transactions should be set forth in regulations under the appropriate federal and provincial legislation.
- D.14 All property and casualty insurers should be required to pass a by-law establishing a committee of the board with responsibility for reviewing and approving all non-arm's-length transactions.

Conflicts of Interest

- D.15 Property and casualty insurance companies should be required to create and maintain "Chinese walls" to prevent the flow of information between certain departments within a company or between affiliated companies where the flow of information might give rise to conflicts between: (i) the interests of customers or claimants of the company; (ii) the interests of a customer and that of the company; or (iii) the interests of a broker or agent and that of the company.
- D.16 The federal and provincial regulatory authorities should consult with trade associations, professional groups, insurance companies and consumer groups in developing guidelines for increased institutional disclosure of information to consumers in view of the increased possibility of conflicts of interest arising from product bundling, corporate affiliations and networking.

Policyholder Compensation Funds

- D.17 A federal policyholder compensation fund for property and casualty insurers should be established as soon as possible and that membership in such a fund be mandatory for Ontario-licensed property and casualty insurers.
- D.18 If the Government of Ontario determines that a federal fund is not to be formed, the Government should establish a fund for the protection of policyholders in consultation with the industry, and membership in such a fund should be mandatory for Ontario-licensed property and casualty insurers.
- D.19 Any fund established should be funded by both regular assessments to allow accumulation of funds and special assessments based on experience.

How are the insurers accountable for their financial activities?

- D.20 The appropriate federal and Ontario legislation should be amended to authorize the respective Superintendents of Insurance to require the filing of interim financial statements from such companies, in such form and with such frequency as required by the Superintendent.
- D.21 The federal and provincial regulatory authorities should expedite completion and implementation of the new uniform annual statement, and all parts of such annual statement should be made available to the public in a cost-efficient form.
- D.22 A permanent federal-provincial consultative mechanism consisting of a council of ministers responsible for financial institutions should be established and early priority should be given to establishing new industry-wide reporting and disclosure requirements with respect to critical aspects of the industry's operation, in particular:

MARKET REGULATION**The Insurance Contract**

- D.23 The right of insurers to design insuring contracts to meet consumer needs without prior approval should be continued, and that the right of the Superintendent of Insurance and Minister to disallow contracts that are unfair, fraudulent or not in the public interest should be maintained.

Brokers and Agents

- D.24 All primary insurers should establish committees with their brokers that will develop mechanisms responsive to consumers and strengthen communication.
- D.26 The Insurance Bureau of Canada and The Insurers' Advisory Organization, together with the Insurance Brokers Association of Ontario, should accept and adopt as their mandate the promotion of risk management services through appropriate arms of the insurance industry, in order that public education of risk management services and loss prevention control can be co-ordinated, promoted, and the public assisted, particularly those insureds facing difficulties with respect to liability insurance coverage.
- D.27 The Government of Ontario, through the Interministerial Committee established to deal with property and casualty insurance problems, should take the lead in encouraging a debate over the appropriate balance of responsibility for such loss prevention measures among individuals or businesses, insurance companies and public bodies. In addition, it should promote more research and development into product and safety standards, more training of personnel in loss prevention and control (see, for example, the IAO's School of Loss Control Technology), and more public education. Finally, the government should require more data collection on the causes and extent of losses of all types.

Superintendent's Role

D.28 The Superintendent of Insurance should include in his annual report to the Minister a special report with respect to the progress of industry associations towards achieving the necessary structural changes to the system encompassed in the foregoing recommendations.

Advance Notice of Changes

D.29 The insurance brokers (through their association, the Insurance Brokers Association of Ontario) and the insurers (through the Insurance Bureau of Canada), under the aegis of the Superintendent of Insurance, should develop guidelines which will ensure timely notification to insureds of changes in price, coverage, exclusions and non-renewal. This recommendation is made on the basis that marketplace guidelines would be the best solution but on the express understanding that failure to arrive at a solution would result in a mandated standard, in each instance, by government regulation.

Rate Regulation

D.30 The Government of Ontario should seriously consider the implementation of a systematic framework for the monitoring, surveillance and evaluation of rates with a view to ensuring greater rate stability and public understanding of the determinants of rates and the basis for the rate changes.

D.31 The Superintendent of Insurance should be required to file an annual report to the Legislature forthwith after the end of a calendar year but not later than April 30, providing disclosure of the loss and expense data and a review of the competitive indicators monitored by his office.

SUPERVISION OF INSURERS

Cease and Desist Orders

D.32 The insurance legislation of Canada and Ontario should be amended to authorize the respective Superintendents of Insurance to issue orders requiring a registered or licensed insurance company to:

- a) cease doing any act or pursuing any course of conduct that might reasonably be expected to prejudice or adversely affect the interests of policyholders of the company or to result in the company being in violation of its governing legislation; and,
- b) take specific courses of action that appear necessary to protect the assets of the company or their value, to ensure that the company carries on its business in a sound, business-like manner and generally to safeguard the interests of policyholders,

and that, in particular, the Superintendent be authorized to proceed without prior notice to the company in circumstances where the vital interests of policyholders or the public may be prejudiced by delay.

Corporate Governance

D.33 Federal and provincial authorities should accord immediate priority to revision of insurance legislation to bring it into line with modern approaches to corporate law generally and sound business practices for insurance companies, and resulting legislative amendments should include a provision requiring regular review of the legislation governing insurance companies.

Supervisory System

D.34 The federal, provincial and territorial governments should immediately establish a Council of Ministers Responsible for Financial Institutions to consider in advance all matters pertaining to the policies and regulatory practices governing financial institutions, including property and casualty insurance companies.

TAXATION

Compensation for Future Care Costs

D.35 The taxation of revenue from lump sum settlements which arise as compensation for the economic losses of injured persons under the heading of costs of future care should be abolished. This would eliminate gross-up with respect to the cost of future care.

D.36 The practice of exempting structured settlements for compensation for the economic losses of injured persons under the heading of costs of future care should be continued and codified.

Self-Funded Reserves

D.37 The tax laws should be changed to allow corporations to take deductions on self-funded reserves in the same way that an insurance company can on its claims reserves, subject to appropriate controls to avoid abuse.

Captive Insurers

D.38 The tax treatment of captive insurance companies should be examined, alongside the regulatory aspects of such captives, with a view to promoting the domestic domicile of such captive property and casualty insurance companies as are considered to be an appropriate part of the Canadian property and casualty insurance markets.

Reserves (Stabilization and Major Shock Losses)

- D.39 Property and casualty insurers should develop, with the tax authorities, a set of rules for the deduction of premium deficiency reserves where an insurer has a premium deficiency reserve program and includes such reserves on its balance sheet and provision should be made for rules regarding additions to such reserves as an expense item for the measurement of the taxable income of the insurers.
- D.40 The industry, the regulatory authorities and the tax authorities should explore means of improving the provision and use of reserves against major shock losses, related particularly to disasters due to natural causes, including the taxation treatment of such reserves.

A MORE ACTIVIST ROLE FOR GOVERNMENTS IN PROPERTY AND CASUALTY INSURANCE

Government Insurance Corporation

- D.41 The Government of Ontario should NOT establish at this time a government insurance corporation to deliver auto insurance services.
- D.42 The Government of Ontario should concentrate its efforts regarding auto insurance on improvements in the design of the system set out in Part C, which it is contemplated will be delivered by an evolving private insurance market system;
- D.43 If the Government of Ontario does choose, for a balance of political and social reasons, to establish a government insurance corporation to deliver auto insurance services, it should take steps as indicated in the Chairman's memorandum to try to ensure a "good performing" rather than a "poor performing" government corporation this is not a simple or easy task.

Governments as Animators in the Property and Casualty Insurance Market

- D.44 The Government of Ontario should consider a more activist role in insurance and reinsurance, in association with the industry, to meet the difficult structural problems of uninsurable risks and uncertainty, particularly as regards products liability (especially in relation to exports to the United States), pollution and environmental risks, the services of the provinces and of its creatures, professional services and voluntary activities. Some of these problems appear to be enduring rather than transitory, and a government insurance corporation may well be an appropriate vehicle for helping to deal with these problems.

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